



CORI v4.2.3.0 User Manual

Contents

Introduction.....	3
Site Administrator	3
Pages.....	4
Login Page	4
Main Lobby	4
Navigation Bar.....	5
Home Page	5
Schedule Page	8
Searching for Records	14
Patients Page.....	18
Procedures Page.....	25
Queries Page	28
Staff Page	30
Referring Providers Page.....	38
Procedure Module.....	40
Procedure Navigation Bar	40
Report Management Buttons	41
Procedure Menus	41
Procedure Field Types.....	43
Preprocedure Section	49
Sedation Section.....	50
Procedure Section	51
Findings Section.....	52
Events Section.....	62
Assessment/Plan Section.....	63
Letters/Instructions Section.....	65
Completing a Procedure Report.....	69
Postprocedure Module	75
Pathology Section	78
Followup Section	87
Letters Section	88
Importing and Exporting in CORI v4.....	93
Patient Information.....	93
Orders	94
Images	96
Exporting From CORI v4	99
Contact Information.....	100

Introduction

CORI Endoscopic Reporting Software, version 4, or CORI v4, is an endoscopic report writer. It is used to create procedure reports for use in medical practices where GI procedures are performed.

CORI v4 is available from Clinical Outcomes Research Initiative (CORI), which develops, distributes and supports it. CORI is a non-profit research company affiliated with Oregon Health & Science University (OHSU), which conducts research on GI procedures and maintains the National Endoscopic Database. More information can be found at the CORI website, at www.cori.org.

CORI v4 can produce additional documentation, such as letters to referring physicians, patient discharge instructions, and post-procedure pathology results. These documents can be printed or sent via fax to referring providers.

CORI v4 can interface with other medical software using several methods, including HL7, an industry-standard communication protocol. CORI v4 can import patient demographic (ADT) data from software such as EMR systems; endoscopic images from electronic imaging systems, and pathology results from pathology management software. In addition, CORI v4 can import these types of information from non-HL7-based systems, including standard computer networks.

CORI v4 can also export procedure reports to medical information systems, either as text or as a PDF with all diagram and image information intact.

This User Manual provides an overview as well as specific instructions on using CORI v4 as part of a standard workflow in a GI department.

Site Administrator

The CORI v4 Site Administrator is the term CORI personnel use to refer to the primary administrative contact in the GI department at the practice site. The Site Administrator is responsible for managing various aspects of the software, including maintaining staff records and handles the on-site administration and configuration of CORI v4. Generally the Site Administrator is the first person users should contact regarding CORI v4; if necessary, the Site Administrator contacts CORI Site Services to resolve any issues beyond the scope of day-to-day administration.

Pages

The following section describes the various pages found when you first open and log into CORI v4.

Login Page

When CORI v4 is first started the Login Page is displayed:



Enter the user's name and password, and press the Enter key to log in to CORI v4. Users are practice site employees who have a Staff record (see [Staff Page](#)) in CORI v4.

Depending on the security settings selected for the user, additional functions may be available throughout CORI v4, and fields to access these functions are displayed when appropriate.

The Site Administrator is responsible for assigning staff roles and security settings (see [Site Administrator](#)).

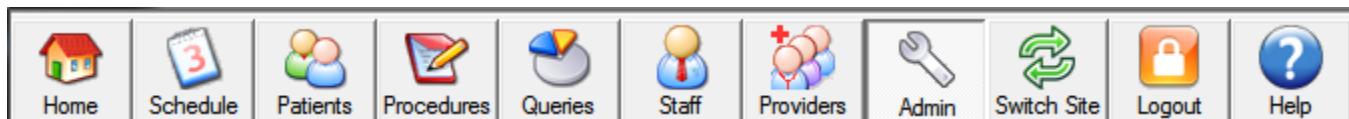
Main Lobby

After login, CORI v4 displays the Home Page (see [Home Page](#)), one of several pages available in the Main

Lobby. The Main Lobby is where the main functions of CORI v4 are accessed, for managing various records, and obtaining information from the CORI v4 database.

Navigation Bar

The navigation bar is displayed at the top of all main pages.

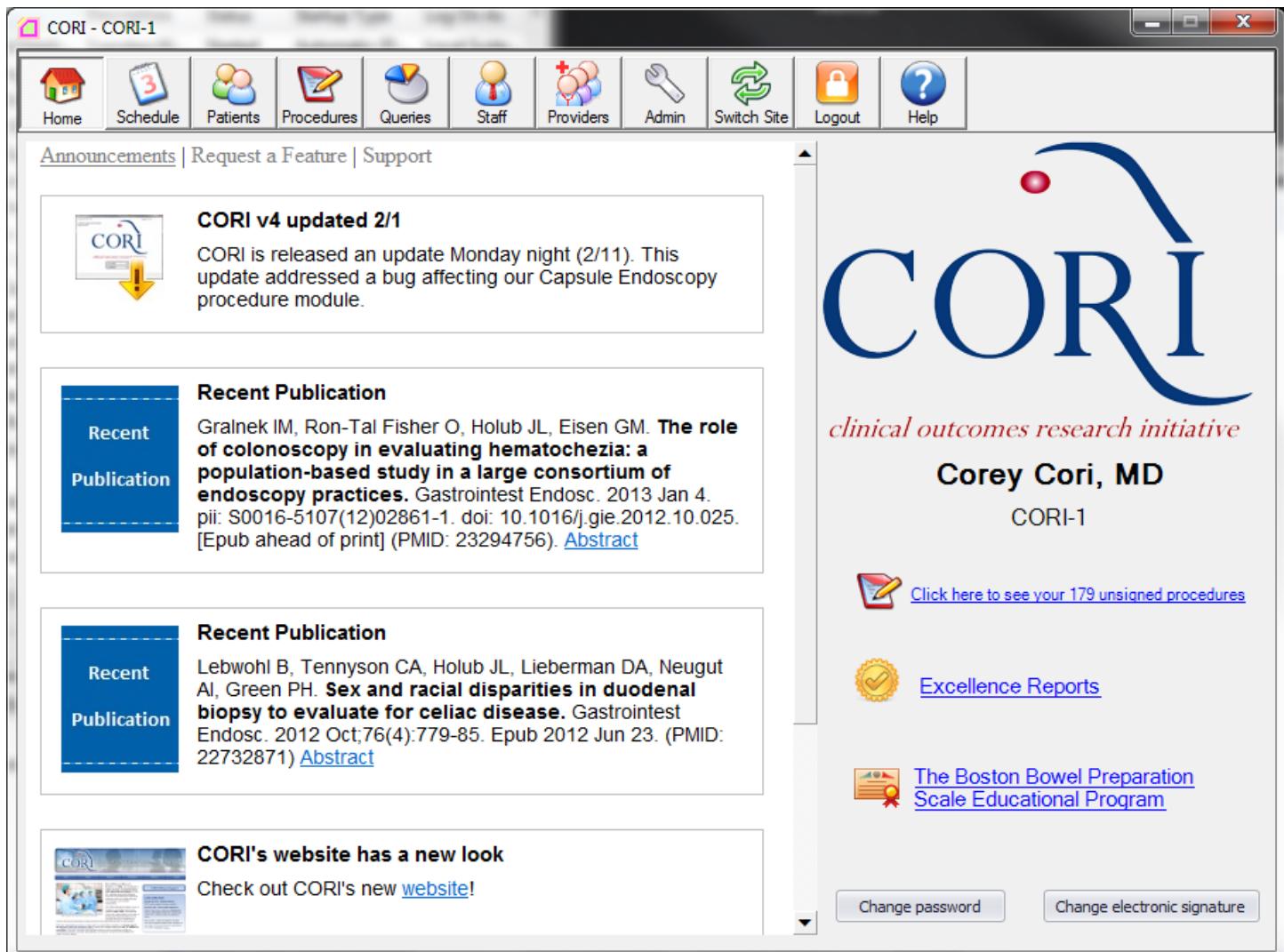


NOTE: Not all of the buttons in the navigation bar are displayed for every user – this depends on the Security settings selected for the user.

The navigation bar deactivates when it is inappropriate to switch to a different page, for example while creating a new patient record.

Home Page

The Home Page is displayed immediately after login. It provides a starting point from which to access the various functions in CORI v4.



The screenshot shows the CORI v4.2.3.0 Home Page. The top navigation bar includes the CORI logo, a search bar, and links for Announcements, Request a Feature, and Support. The main content area features several sections: a 'Recent Publication' box for a study on colonoscopy, another for a study on sex and racial disparities in duodenal biopsy, and a third for CORI's new website. On the right, there is a large CORI logo, a sidebar with links for procedures, excellence reports, and the Boston Bowel Preparation Scale Educational Program, and buttons for changing password or electronic signature.

The Home page consists of the following areas:

Announcements: Announcements regarding CORI v4 will appear in the large area on the left half of the page. Click the [Provide feedback to CORI](#) link at the top of the Announcement area to display a Web browser Window, allowing users to provide feedback on, or request help with, CORI v4.

Unsigned Procedures Link: The [Click here to see your ... unsigned procedures](#) link next to the announcements area takes users with Endoscopist or Bronchoscopist staff roles (see [Staff Roles](#)) to the Procedures Page (see [Procedures Page](#)), where a list of unsigned procedures in which the user is listed as the Responsible Endoscopist / Bronchoscopist (see [Responsible Endoscopist / Bronchoscopist Field](#)) are displayed in the search result (see [Searching Records in CORI v4](#)).

Excellence Reports Link: Clicking on this icon links the user to their Excellence Reports webpage, a quality measures tool CORI has developed that allows users to compare individual, practice, and national quality indicators. For further information, please visit http://www.cori.org/?topic=news&sub=excellence_reports_tutorial.

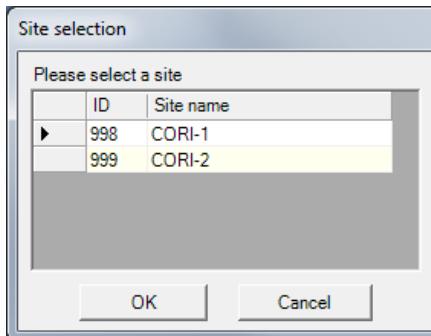
Boston Bowel Preparation Scale Education Program: The Boston Bowel Preparation Scale is a standardized scale used for documenting bowel prep. The Education Program provides a tutorial on using the scale; 0.5 hours of CME credit is available when you finish the tutorial.

User: Displays the name of the user currently logged in to CORI v4. To change users, click on  in the Navigation bar to return to the Login Page, and log in as a new user (see [Login Page](#)). **Associated Sites:** CORI v4 allows one or more practice sites to maintain their own CORI v4 facility on a single installation. This allows separate practices using the same network or server to maintain their own data while minimizing maintenance and administration. While many endoscopists practice at multiple CORI sites, these sites are not considered associated until such a relationship has been established in the CORI v4 software. This requires the assistance of CORI personnel and is usually done at the time of installation.

In the Associated Sites area, all sites available to the current user are listed, with the currently selected site highlighted. The Site Administrator associates users with sites in the user's Staff record (see [Staff Page](#)).

To switch associated sites:

1. Click on  in the Navigation bar. The Site Selection Screen appears
2. Click in the row of the desired site.
3. Click on  to switch sites or on  to remain in the current site.

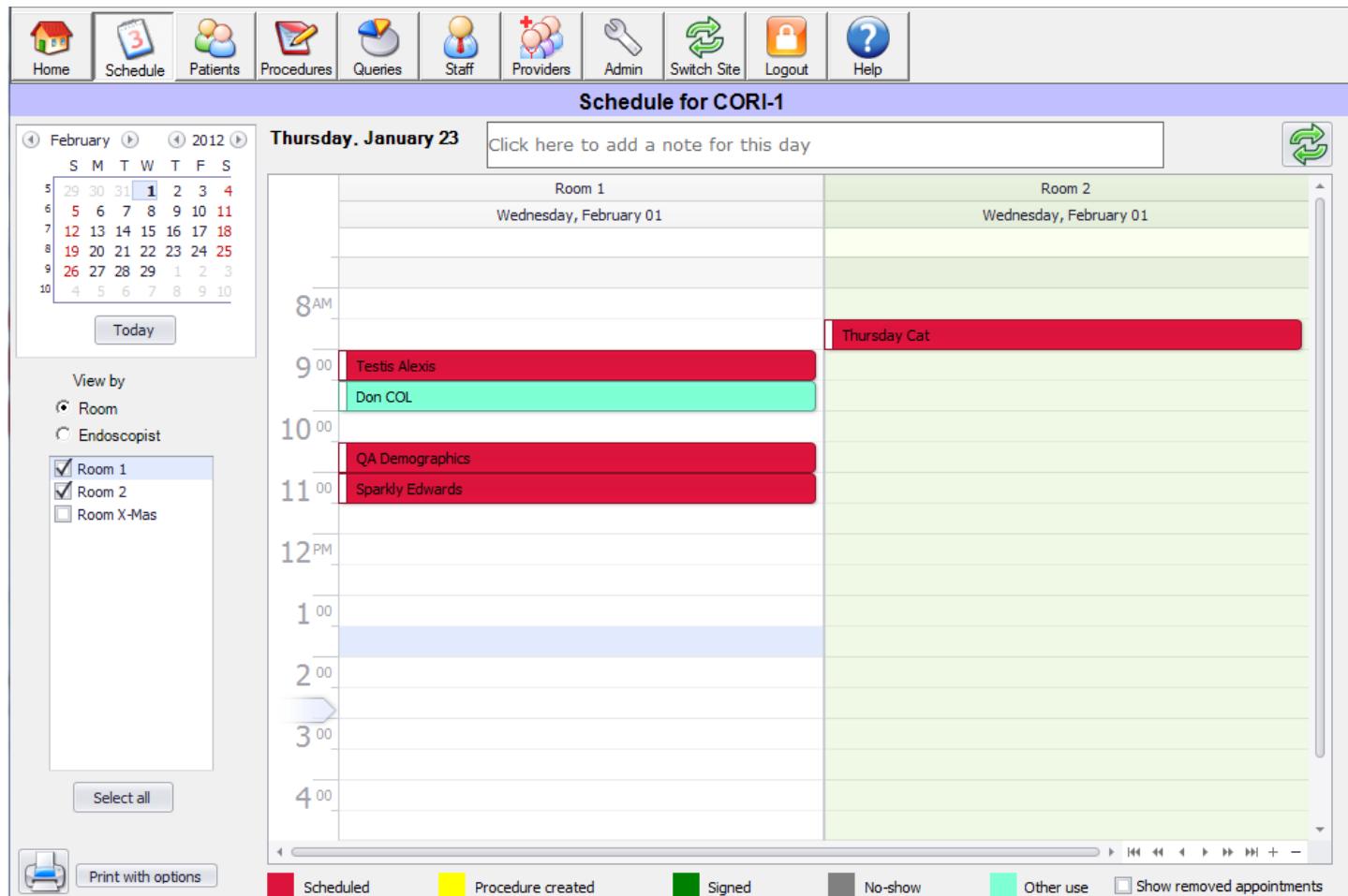


Password (Signature): Allows the user to change their password or electronic signature (see [Signing a Procedure report](#)). To change a password (signature):

1. Select "Change password (electronic signature)" checkbox.
2. For passwords, enter the current password into the "Old password" text box.
3. Type the new password (signature) into the "New password (signature)" text box.
4. Type the new password (signature) into the "Confirm new password (signature)" field.
5. Click  to save the new password (signature), or on  to discard the changes.

Schedule Page

The Schedule Page is where appointments are managed. An appointment can be scheduled in advance of creating an associated procedure record (see [Creating a Procedure Record](#)), or the procedure record can be created at the same time (see [Creating a Procedure Record from an Appointment](#)).



The screenshot shows the CORI Schedule Page. At the top, there is a navigation bar with icons for Home, Schedule, Patients, Procedures, Queries, Staff, Providers, Admin, Switch Site, Logout, and Help. Below the navigation bar is a title bar that says "Schedule for CORI-1".

On the left, there is a calendar for January 2012, showing the days of the week (S M T W T F S) and the dates from 29 to 10. A "Today" button is located below the calendar. To the right of the calendar is a text box that says "Click here to add a note for this day".

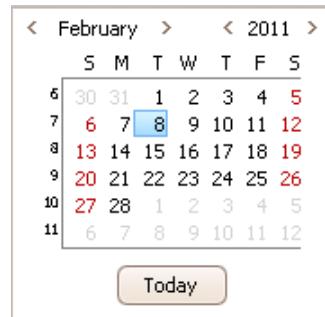
The main area is a grid representing a day's schedule. The columns are labeled "Room 1" and "Room 2". The rows represent time intervals from 8 AM to 4 PM. Appointments are represented by colored bars: red for "Testis Alexis" and "Don COL", green for "QA Demographics", and blue for "Sparkly Edwards". A red bar labeled "Thursday Cat" spans the entire time from 9 AM to 12 PM. The bottom of the grid has a legend with colored squares and labels: "Scheduled" (red), "Procedure created" (yellow), "Signed" (green), "No-show" (dark grey), "Other use" (light green), and "Show removed appointments" (grey).

The Scheduling Page consists of the following areas:

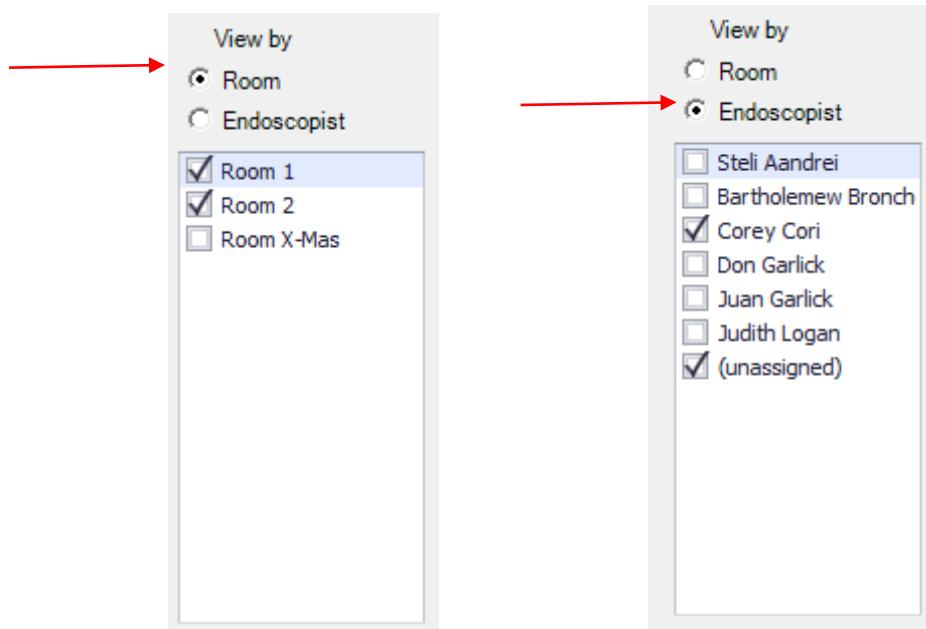
Notes for the day: Here, you can make small notes to display at the top of the calendar. Click in the text box to create a note.

Thursday, January 23 Click here to add a note for this day

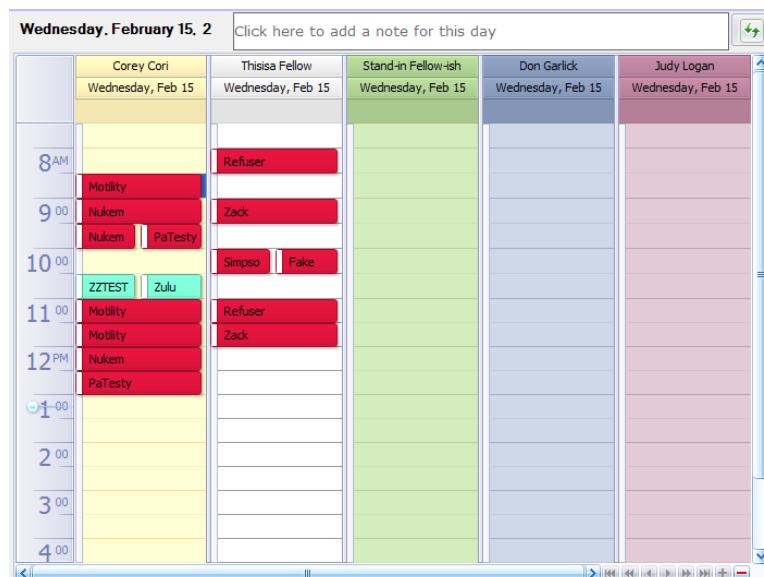
Scheduling Calendar: Click on a date in the calendar to display the appointments for the date in the appointment display. Click on the < and > symbols surrounding the month and year to change them. Click on **Today** to return to the current date.



"View by" Option Group: Select an option to view the schedule by room or by endoscopist.

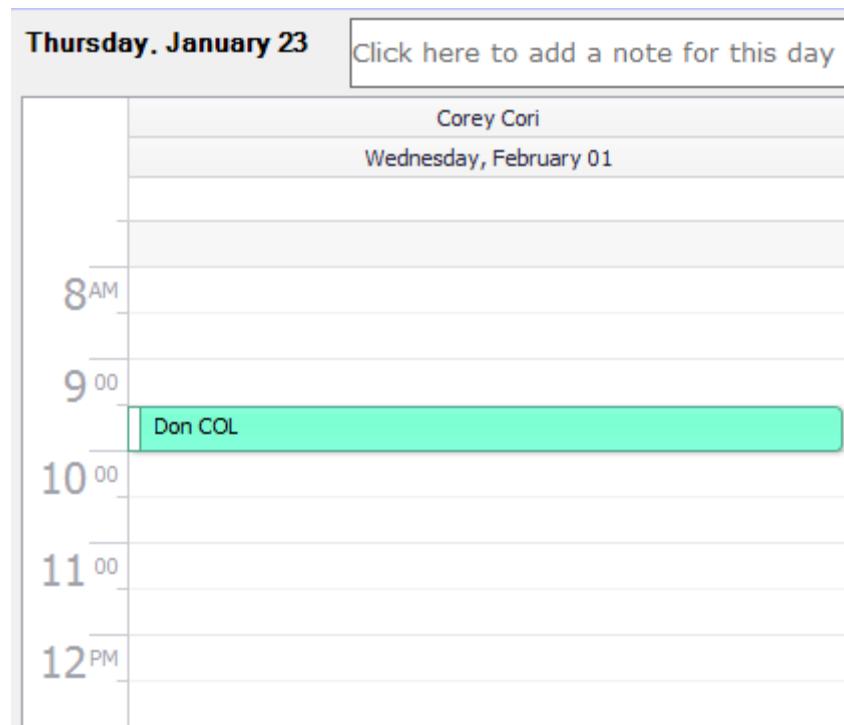


The entries in the list below the option group can be selected to add or remove their associated columns from the appointment display. Click on **Select all** (when at least one entry is not checked) to select all the entries in the list, or on **Unselect all** (when all entries are checked) to clear them all.



Example of Endoscopist View

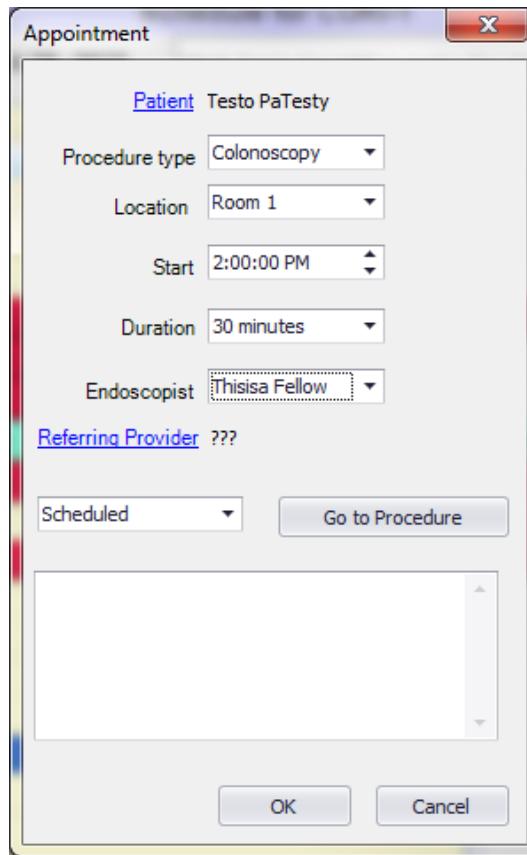
Appointment Display: Appointments are displayed in the main area of the page. The time scale on the left border of the display indicates the time and duration of appointments, based on the position and height of the appointment entries. Each column in the appointment display represents a room or an endoscopist, depending on the setting of the "View by" option group.



Creating a Procedure Appointment

A Procedure Appointment may be created by room or by endoscopist, depending on the appointment display.

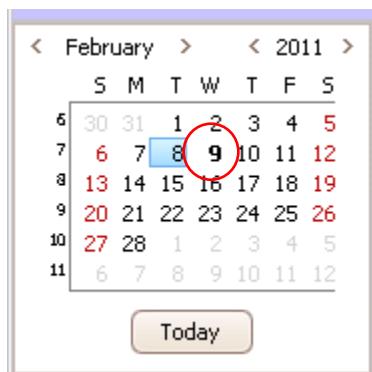
1. Use the calendar in the upper left to select an appointment date, and double-click on the appointment display in the appropriate column and time slot. Alternatively, right-click in the appropriate column and time slot and select "New Appointment" from the menu.
2. An Appointment screen appears. Fill in appointment details as needed. Appointments must contain a patient, location, start time, duration and an endoscopist.



3. Click on the Patient link to display the Patient Screen, which is similar to the Patients Page (see [Patients Page](#)). To select a patient from this screen:
 - a. Search for the patient record.
 - b. Select the patient on the left. (see [Searching Records in CORI v4](#) for more information).
 - c. Click to select the patient or click on to return to the dialog without selecting a record.
4. Select the procedure type or location as needed.
5. Change the Start and Duration times if needed.
6. Click on the Referring Provider link to display the Providers Screen, which is similar to the Providers Page (see [Providers Page](#)).
 - a. Search for the correct Provider (see [Searching Records in CORI v4](#)).
 - b. Click on to enter the record into the Appointment Screen or click on to return to the dialog without selecting a record.
7. Click on to create a new procedure record or display an existing one (see [Creating a Procedure Record from an Appointment](#)).
8. Enter notes into the large text field near the bottom of the dialog, if desired. If there is text entered into comment box the appointment will have a black bar  next to appointment block in the schedule display.

9. Click on **OK** to create the appointment, or on **Cancel** to return to the Schedule Page without creating one.

The appointment appears in both the Room and Endoscopist views. It will also be indicated on the calendar as the appointment date displayed in **bold** text.



Moving, Changing and Deleting an Appointment

On the schedule display an appointment can be moved by dragging it from one timeslot to another, from one column to another, or to a date in the calendar.

The appointment duration can be changed by dragging the top or bottom border of the appointment to the desired timeslot.

An appointment can be deleted by: right-clicking on the appointment and selecting Delete from the menu, left-clicking on the appointment and pressing the Delete key on the keyboard, or by opening the appointment and changing its status to "Delete."

Creating a Procedure Record from an Appointment

Creating an appointment does not create a procedure record. This way, if the appointment is subsequently cancelled there need not be procedure record that must be deleted.

To create a procedure record from an appointment, click **Go to Procedure** in the Appointment Screen.

At this point, available procedure information can be entered (see [Creating a Procedure Record](#)). Once the Procedure Window is displayed, the procedure record must be saved before returning to the schedule, otherwise the record will not be created.

Appointment Colors

Entries in the appointment display can appear in different colors. As indicated in the legend on the bottom of the page:

- A red appointment indicates that the appointment is scheduled but a procedure record has not been created.
- Yellow means that a procedure record has been created but not signed.
- Green means the procedure record has been signed.
- Gray means the appointment was a no-show.
- Light blue indicates that the appointment is scheduled as "Other use", one of the options in the "Procedure type" menu of the Appointment screen.
- Black bar on the left side of the appointment block indicates there is text in the comment field.

To change the status of an appointment to "No-show" or "Cancelled," right-click on the appointment and select the desired status from the menu, or open the appointment and change its status.

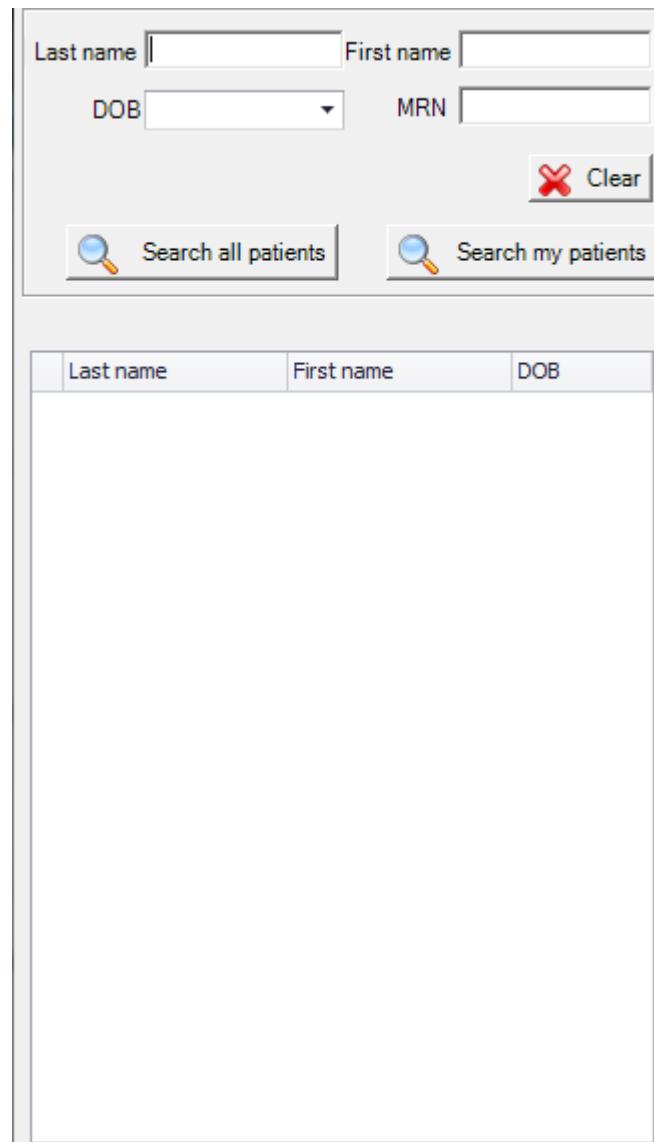
To set the appointment to "Other use," open the appointment and select "Other use" in the "Procedure type" menu.

Notes on Scheduling and Appointments

Appointments ranging from two weeks before the current date, to 364 past the current date, appear as bold dates in the appointment calendar. Appointments cannot be created with a date more than 364 days beyond the current date.

Searching for Records

Various pages and screens throughout CORI v4 provide an area for searching records. The search functionality is nearly identical, differing only in the available search criteria and the information displayed in the Search Results Display. A typical Search Area is displayed below:



Last name	First name	DOB
-----------	------------	-----

General Notes on Searching

- All record management functions must begin with a search.
- It is strongly recommended to search using criteria. While it is possible to perform a search without entering any search criteria, the result can contain dozens to thousands of records.
- Searching should be done with increasing specificity. For example, begin a patient search with a few letters of the last name. With common last names, use the entire last name and one or two letters of the first name. Use more letters or additional criteria to narrow down a large search result. If a search produces no results, remove letters or individual criteria and search again.

Instructions for Searching

1. Enter search criteria as needed. See [General Notes on Searching](#).
2. Click on or .
3. Search results are displayed in the Search Results Display.

100 patients found		Limited to 100 patients
Last name	First name	DOB
ALEXANDER	Aga_pt96	4/30/1952
BAILEY	Aga_pt60 S	6/7/1954
Barbar	Ellen MiddleEarth	9/1/1957
BELL	Aga_pt58	5/2/1961
BROOKS	Aga_pt73	9/22/1954
BROWN	Aga_pt5	2/14/1975
BRYANT	Aga_pt95	10/28/1925
BUTLER	Aga_pt91 L.	8/29/1946
CAMPBELL	Aga_pt46	9/30/1951
CARTER	Aga_pt40	7/31/1963
CLARK	Aga_pt21	2/1/1952
COL	Don	1/1/1991
COLEMAN	Aga_pt82 M	12/22/1928
COLLINS	Aga_pt50	8/16/1946
COOK	Aga_pt56 M	12/20/1949
COX	Aga_pt64	2/16/1951
DAVIS	Aga_pt6	11/30/1952
Demographics	QA	1/1/1991

4. Click on a column header to sort the displayed results by that column. Alternate clicks will reverse the sort order.
5. To sort the entire result, right-click anywhere in the Search Results Display and select a column name to sort by.

NOTE: Clicking on the column names will sort the list by that column. An arrow will appear next to the column name to show if it is sorting by descending (down arrow) or ascending (up arrow) order. So for example, if you select the Last Name column, the search results will sort by last name, if the arrow is pointing up, the list is displayed in ascending order, or A to Z.

6. Click on a row in the search results to display the record details, generally on the right.

Page-Specific Notes on Searching:

- On the Patients and Procedures Pages, users with an Endoscopist or Bronchoscopist staff role (see [Staff Roles](#)) may click the  button to further narrow the search to records in which the user is identified as the "Responsible Endoscopist" in the procedure record (see [Responsible Endoscopist/Bronchoscopist Field](#)).
- On the Patients and Procedures pages, procedure and post procedure reports that have not been signed cannot be viewed (see [Signing a Procedure report](#)).
- On the Patients Page, the national identifier (e.g. SSN) and patient identifier (e.g. MRN) search fields may not be visible – this is determined by the Site Administrator.
- On the Patients Page, a list of procedure records associated with the patient record selected in the Search Results Display appears in the table next to the result. Double-clicking a row in this table displays the procedure record in the Procedure Window (see [Procedure reports](#)).
- On the Procedures Page, double-clicking a row in the search result displays the procedure record in the Procedure Window (see [Procedure reports](#)).
- On the Procedures Page, search results may be filtered using the drop down menus in the search area. It is possible to filter results based on entry of pathology results, entry of followup information, printing of letters, site, and if the procedures have been signed. Specific definitions of the filters are as follows:

Pathology - "Pending" retrieves records where nothing has been entered into the Pathology screen in the postprocedure module. "Entered" retrieves records where one or more characters has been entered anywhere in the Pathology screen in the postprocedure module [or a pathology report has been imported](#). "None sent" retrieves records where no samples were sent to pathology, or a pathology sample was not entered.

Followup - "No" retrieves records where nothing has been entered into the Followup screen in the postprocedure module. "Yes" retrieves records where one or more characters has been entered into the Followup screen in the postprocedure module.

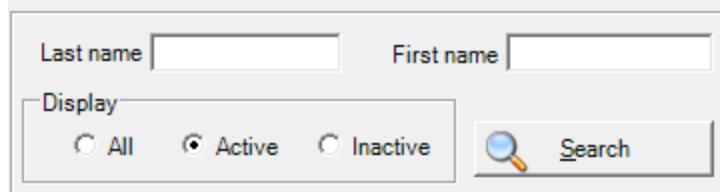
Letters Printed - "No" retrieves records where procedure or postprocedure letters have not been printed or faxed. "Yes" retrieves records where procedure or postprocedure letters have been printed or faxed.

Site - If the user is active at more than one site, the drop down menu will display the associated sites to be chosen from.

Procedure signed - "Yes" retrieves records that have been signed by a responsible endoscopist. "Fellow" retrieves records that have been signed by a fellow but not a responsible endoscopist. "No" retrieves records that have not been signed by a responsible endoscopist.

Pathology	All
Followup	All
Letters Printed	All
Site	All
Procedure signed	All

- On the Staff Page, users with the "View inactive staff" permission may search for active staff records, inactive records, or both (see [Active and Inactive Staff Records](#)) by selecting the appropriate option in the "Display" option group.



- The Patient and Provider Screens function similarly to their counterpart pages. These are reached by links on the Appointment Screen (see [Creating Appointments](#)) and the Letters/Instructions Section in the Procedure window (see [Referral Letters](#)). There may be some elements missing from these screens when it is inappropriate to display them (e.g. the procedure record creation area). Click on Select to select the record highlighted in the search results and return to the previous window, and on Close to return to the previous window without selecting a record.

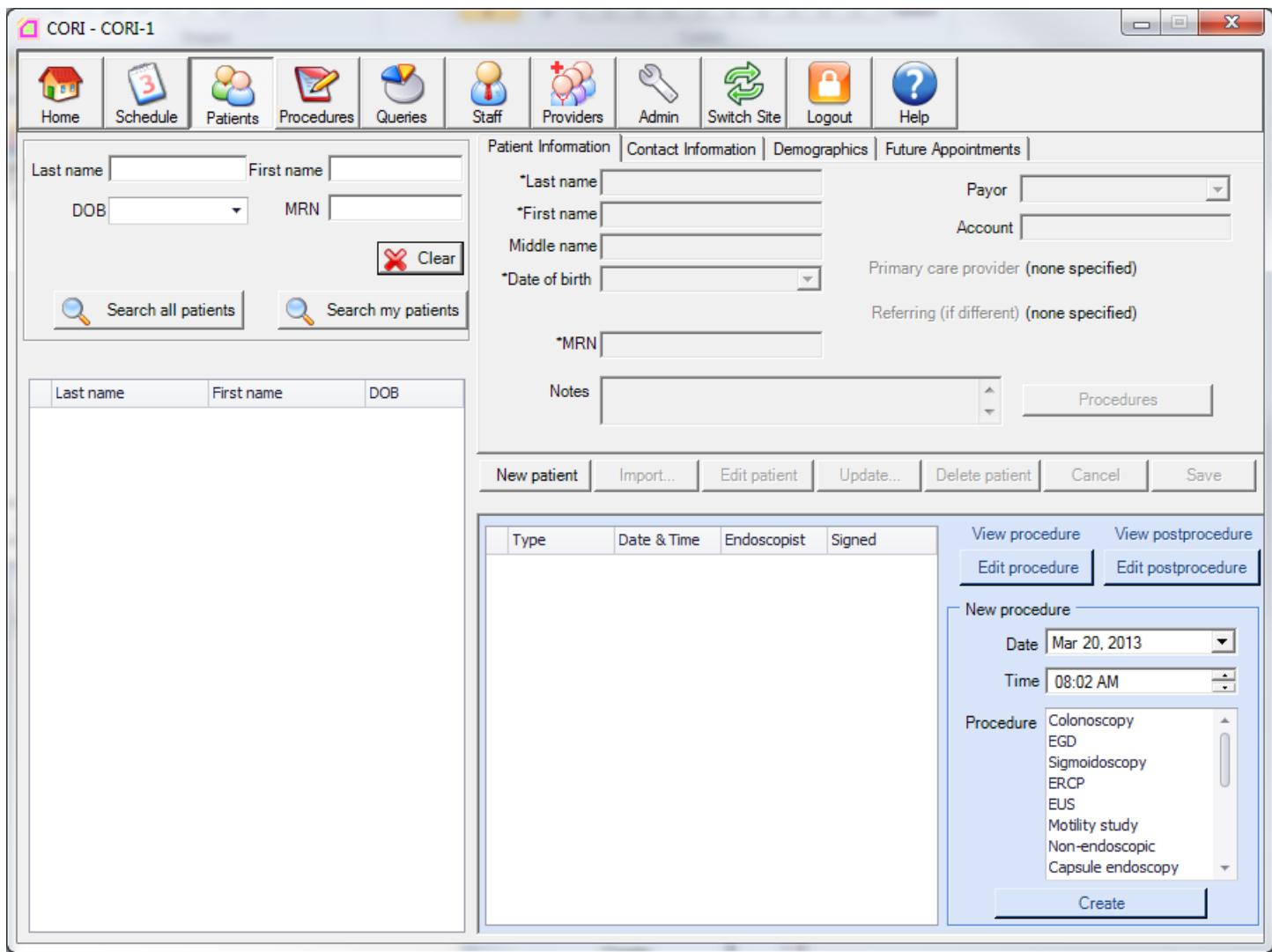
The Signed Column

In the Procedures Page search results and the Patients Page procedures list, the "Signed" column indicates whether the procedure has been electronically signed (see [Signing a Procedure report](#)).

In an educational environment where a fellow may sign the procedure record, the "Signed" column may contain the value "Fellow." This indicates that the procedure has been signed by a fellow, but not yet counter-signed by an Attending physician (see [Fellow Signature](#))

Patients Page

The Patients Page is where patient records are managed. Procedure records are created from this page and can be viewed or opened from here as well.



The Patients Page consists of the following areas:

Search: The top left area of the screen is used to search for patients only. See [Searching Records in CORI v4](#).

Tab Block: Displays the details of the patient record selected in the Search Results Display. Click on [New patient](#) or [Edit patient](#) to add or change patient records. Also, once a patient has been selected, open the Procedure Page for that patient by clicking the [Procedures](#) button.

Procedure Display/Creation: Displays existing procedure and postprocedure records for the selected patient record. New Procedure records are created in this area (see [Creating a Procedure Record](#)).

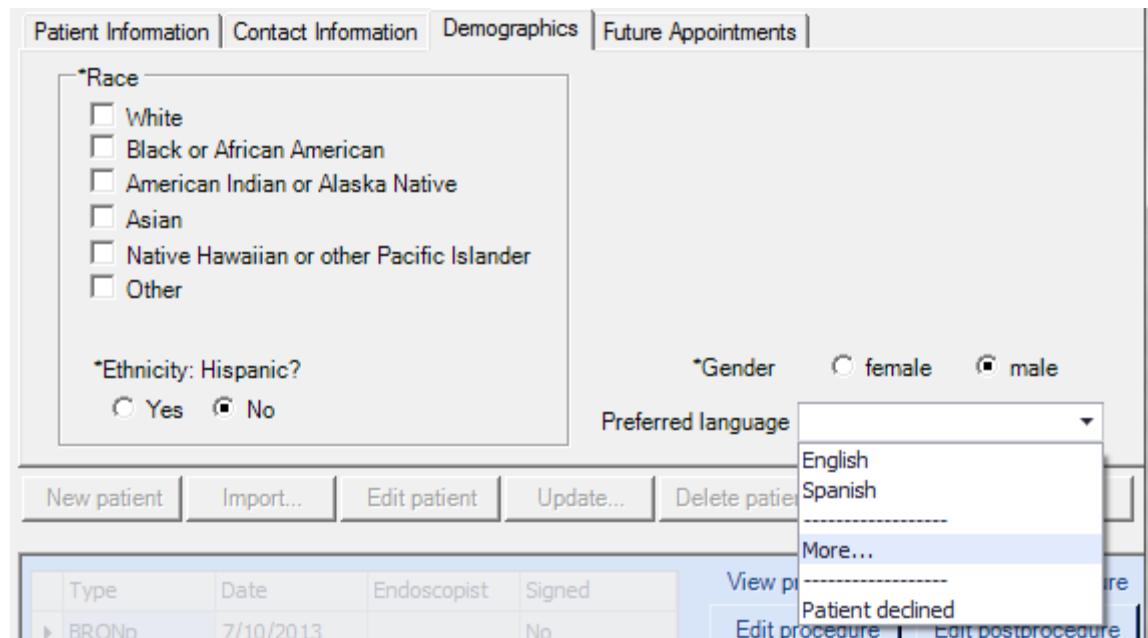
Creating a Patient Record

1. A search must be performed before a new patient record is created (see [Searching Records in CORI v4](#)).
2. Click on **New patient** to create a new record.
3. Enter information as needed:
 - Required fields are denoted by asterisks and must be completed in order to save the record. Note that this includes the Zip code field on the Contact Information tab.
 - The Race and Ethnicity fields are both required; however, they can be completed when the procedure is signed (see [Signing a Procedure report](#)).
 - If the National Identifier (e.g. SSN) field is visible it is required, although the SSN Refused checkbox will satisfy the requirement. The patient identifier (e.g. MRN) field is also required if it is visible. If both fields are visible then at least one must be completed. These fields are set on or off by the Site Administrator.
4. Click on **Save** to save the new record. It will appear in the Search Results display as the only entry.
5. Click on **Cancel** to discard the entire record.

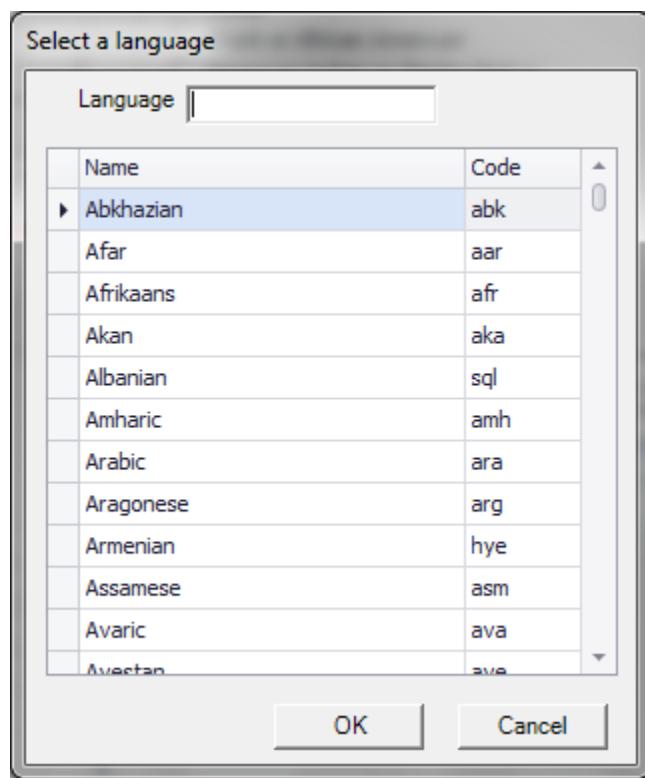
NOTE: If CORI v4 has been set up to communicate with a patient record management system (e.g. an EMR), information can be added to a new patient record via the Image Import Screen (see [Importing and Exporting in CORI v4](#)).

Demographic Information

You can select the preferred language the patient uses. The two most common options are displayed in the drop down.



Selecting *more* allows you to view additional languages.



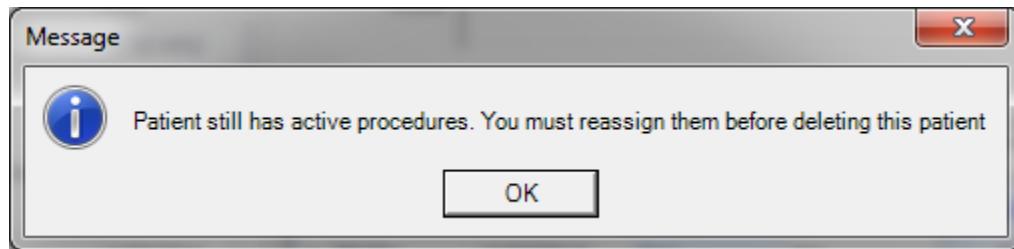
You can search through the languages or click and select the language manually.

Editing an Existing Patient Record

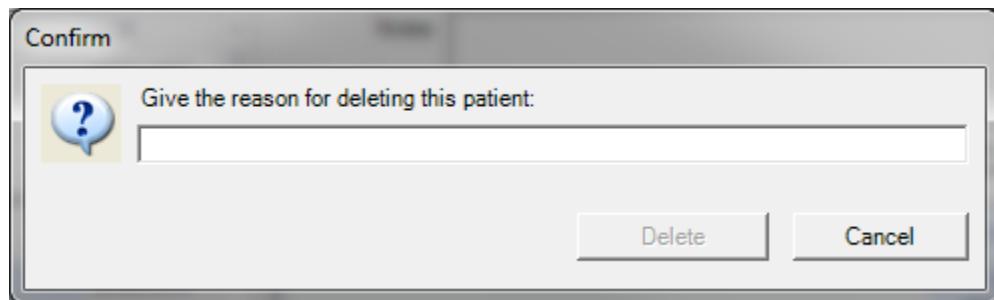
1. Search for the desired patient record as described in [Searching Records in CORI v4](#).
2. Click on the desired row in the search results to select the record.
3. Click on .
4. Edit the fields as needed.
5. Click on  to save the record, or on  to discard the changes.

Deleting a Patient Record

To delete a patient record, a user must have the security permission to do so, and the record must not have any Procedure records associated with it.



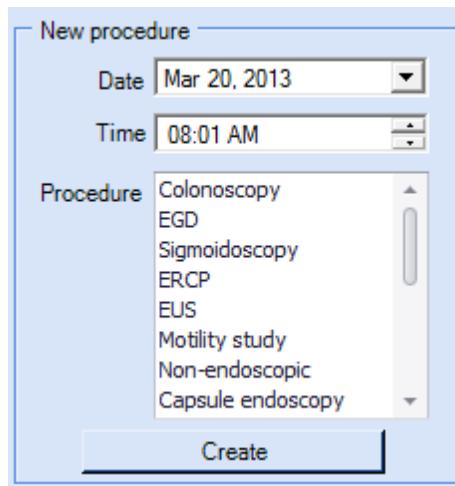
1. Search for the desired patient record as described in [Searching Records in CORI v4](#).
2. Click on the desired row in the search results to select the record.
3. Click on **Delete patient**. A screen appears requesting a reason for the deletion.



4. Enter a reason for deleting the patient record.
5. Click on **Delete**.

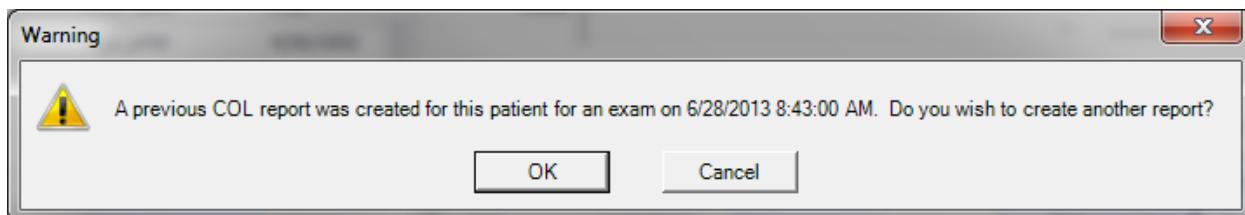
Creating a Procedure Record

1. Search for the desired patient record as described in [Searching Records in CORI v4](#).
2. Click on the desired row in the search results to select the record.
3. In the procedure creation area on the bottom right of the Patient Page, ensure that the procedure date and time are correct.



4. Select the desired procedure type from the Procedure list.
5. Click on Create.
6. The Procedure Window is displayed. See [Procedure Window](#) for information on entering procedure information.

NOTE: If a second procedure of the same type is created within 24 hours of the first, a warning will be displayed:



Opening an Existing Procedure Record

When a patient record is selected in the Search Results, the patient's Procedure records, if any, are listed in the Procedure display area.

To edit an existing procedure, double-click on the beige rectangle at the left of the desired procedure row, or click on the rectangle and click on Edit procedure.

Type	Date & Time	Endoscopist	Signed
COL	8/2/2012	Cori	Yes
EDG	8/1/2012	Cori	Yes
COL	7/31/2012	Cori	Yes
COL	7/31/2012	Cori	Yes
COL	6/27/2012	Fellow-ish	No
EUS	6/20/2012	Cori	No
COL	4/24/2012	Cori	No
FLX	4/3/2012	Fellow	Yes
COL	3/28/2012	Cori	Yes
COL	3/18/2011	Cori	No
BRON	3/11/2011	Aandrei	No
COL	2/23/2011	Cori	Yes
COL	2/23/2011	Cori	Yes

[View procedure](#) [View postprocedure](#)

[Edit procedure](#) [Edit postprocedure](#)

New procedure

Date: Mar 20, 2013

Time: 08:03 AM

Procedure:

- Colonoscopy
- EDG
- Sigmoidoscopy
- ERCP
- EUS
- Motility study
- Non-endoscopic
- Capsule endoscopy

[Create](#)

If the current user has the security permission to edit procedures, the procedure record will open in edit mode; otherwise it will open as read-only with a warning at the bottom.

Viewing and Editing Procedure and Postprocedure reports

To view the current version of a signed procedure or post procedure report, click on the beige rectangle at the left of the desired procedure row and click "View procedure" or "View post procedure".

Procedure and post procedure records can be edited by selecting [Edit procedure](#) or [Edit postprocedure](#). It is also possible to view and edit these reports from the Procedure page.

Emergency Access

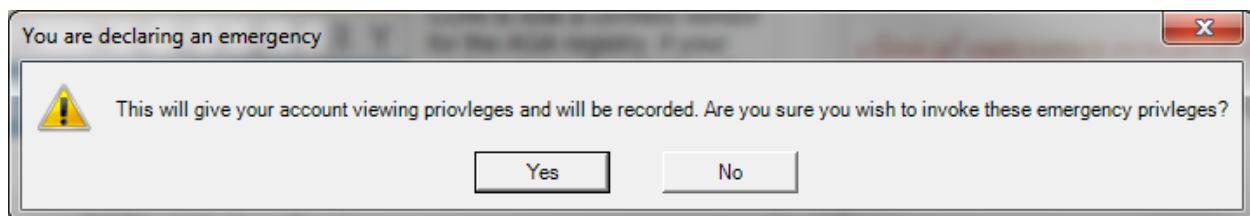
CORI has an option that allows users with limited permissions to have greater access for a short period of time. Called "Emergency Access" the user would be able to perform their usual tasks, as well as: view procedure, view patient information, and view the scheduler. CORI tracks and logs all behavior by a user when this option is used by a user.

Note: This option is off by default, and has to be set up and configured by CORI before you can use it. It is not a default feature.

If enabled at your site, a user can turn it on by clicking the "Enable Emergency Access" button in the upper right hand corner of the screen.



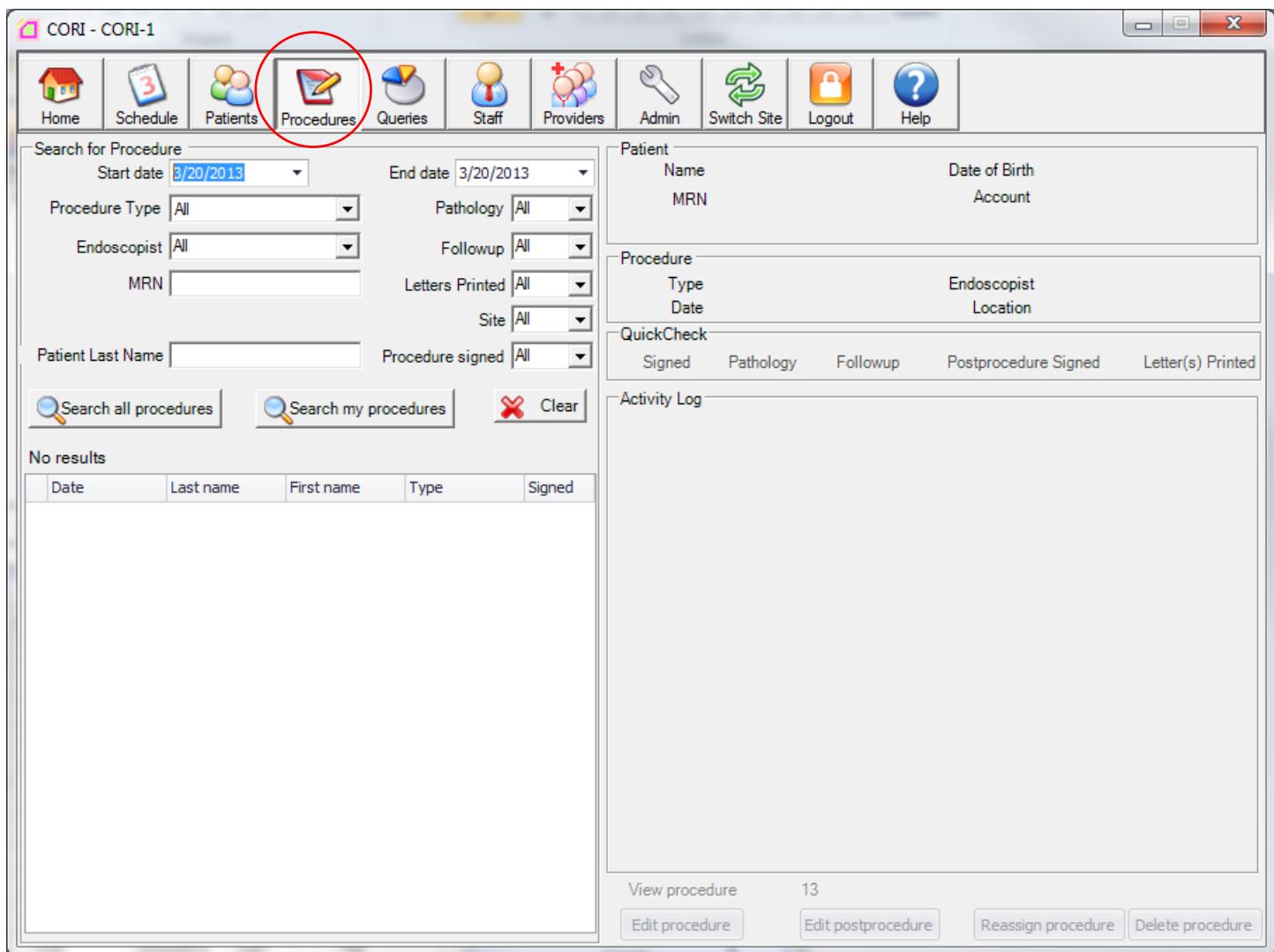
When selected, this is the window that appears.



This can add additional functionality with personnel, but is not turned on in the program by default.

Procedures Page

The Procedures Page is where procedure records are managed. Summary information about the procedure record is available on this page, and all of the CORI v4 documents associated with the procedure record can be viewed from here as well. The Postprocedure window (see [Postprocedure Window](#)) can be accessed here, as well as the Patients Page.



NOTE: New procedure records cannot be created in the Procedures Page. They must be created in the Patients Page (see [Creating a Procedure record](#)) or the Schedule Page (see [Creating a Procedure Record from an Appointment](#)).

The search functionality on this page is extensive; it allows for very precise searches for specific procedure records based on several criteria – see [Searching Records in CORI v4](#).

NOTE: CORI v4 automatically performs a search for all of today's procedures the first time this page is displayed after login. After that all searches must be performed manually.

The Patient and Procedure areas display summary information about the patient undergoing the procedure, and the procedure itself.

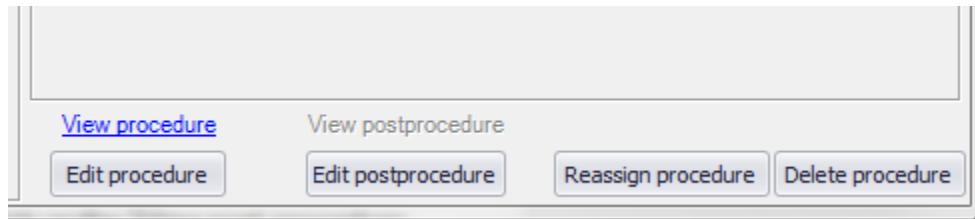
The QuickCheck Area

The QuickCheck area provides a visual summary of the “life cycle” of a procedure report. Checkmarks appear next to each entry in this area to indicate that a certain step – signing the procedure report, for example – has been completed:

- Signed – checked if procedure signed
- Pathology – checked if anything is entered or selected in the pathology grid or Notes field, or a pathology document is attached
- Followup – checked if any amount of text is entered anywhere in the followup screen
- Postprocedure signed – checked if post procedure signed
- Letter(s) printed – any post procedure letters printed or faxed

The Activity Log area displays a running list of significant events in the life cycle of a procedure report. Most entries in the log include “view” links to allow the document – in the state it was in at the entry’s point in time – to be previewed.

Below the Activity Log area are buttons for viewing and editing the procedure and post procedure. In addition, there are buttons for reassigning the procedure (in case the record was inadvertently created for the wrong patient) and deleting it (in case the actual procedure was cancelled, for example).



Viewing or Editing a Procedure Record

To view the latest version of a signed procedure report, click on the “View procedure report” link above the [Edit procedure](#) button. A preview of the report will appear in a new window.

To edit a procedure record, click on [Edit procedure](#) to go to the Procedure Window (see [Procedure Window](#) for more information).

Viewing or Editing a Postprocedure Record

To view the latest version of a signed post procedure report, click on the “View post procedure report” link above the [Edit postprocedure](#) button. A preview of the report will appear in a new window.

Clicking on [Edit postprocedure](#) will display the Postprocedure Window (see [Postprocedure Window](#)).

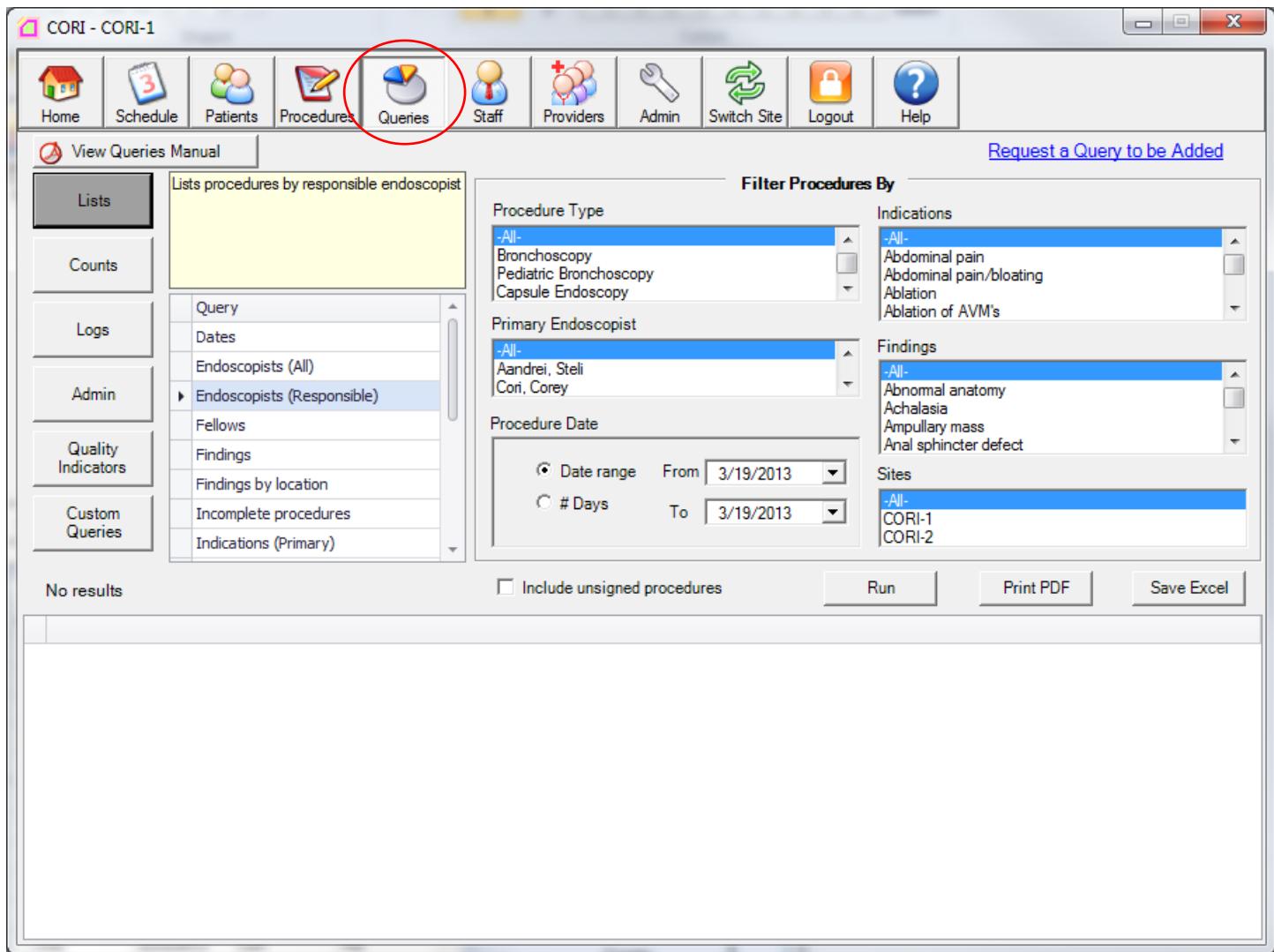
If Cori v4 is configured to use the Postprocedure Window, all postprocedure information appears on the postprocedure report – there will be no Postprocedure section on the procedure report.

Reassigning or Deleting a Procedure Record

A user with the proper security permissions can reassign a procedure to a different patient record, or delete a procedure record. Generally this is handled by the Site Administrator, and specific instructions for these functions are in the CORI v4 Administrator Manual.

Queries Page

CORI v4 contains approximately 50 different queries in the Queries Page, allowing the information entered into CORI v4 to be analyzed for statistical information that may be helpful for practice management or quality measurement purposes.



The Queries Page displays the following areas:

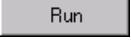
Query Category Buttons: Display a group of queries related by category, such as Lists, Counts, etc.

Queries List: Displays the queries for a category. The description of a selected query is shown above the list.

Filters: Provide criteria for narrowing the scope of a query. The contents of this area change depending on the query selected.

Query Results Display: Displays the list of results from a query.

Running a Query

1. Select a query category by clicking its button.
2. Selecting a query from the queries list.
3. Select filter criteria if desired, by selecting entries in the various filter controls. Hold down the CTRL key while clicking to select multiple criteria within each filter.
4. Set a date range for the query by selecting the Date Range option and navigating the Start Date and End Date calendar controls, or by selecting the # Days option and entering the number of days of historical data to query.
5. Select or clear the "Include unsigned procedures" checkbox to include or exclude unsigned procedure records in the result.
6. Click on  Run to display the results of the query.
7. Click on  Print PDF to create and display a formatted PDF of the query results, which can be printed or saved.
8. Click on  Save Excel to create a file that can be imported into a spreadsheet program such as Microsoft Excel. A "Save As" dialog appears to allow the user to select a location for saving the file.

Adding Queries to CORI v4

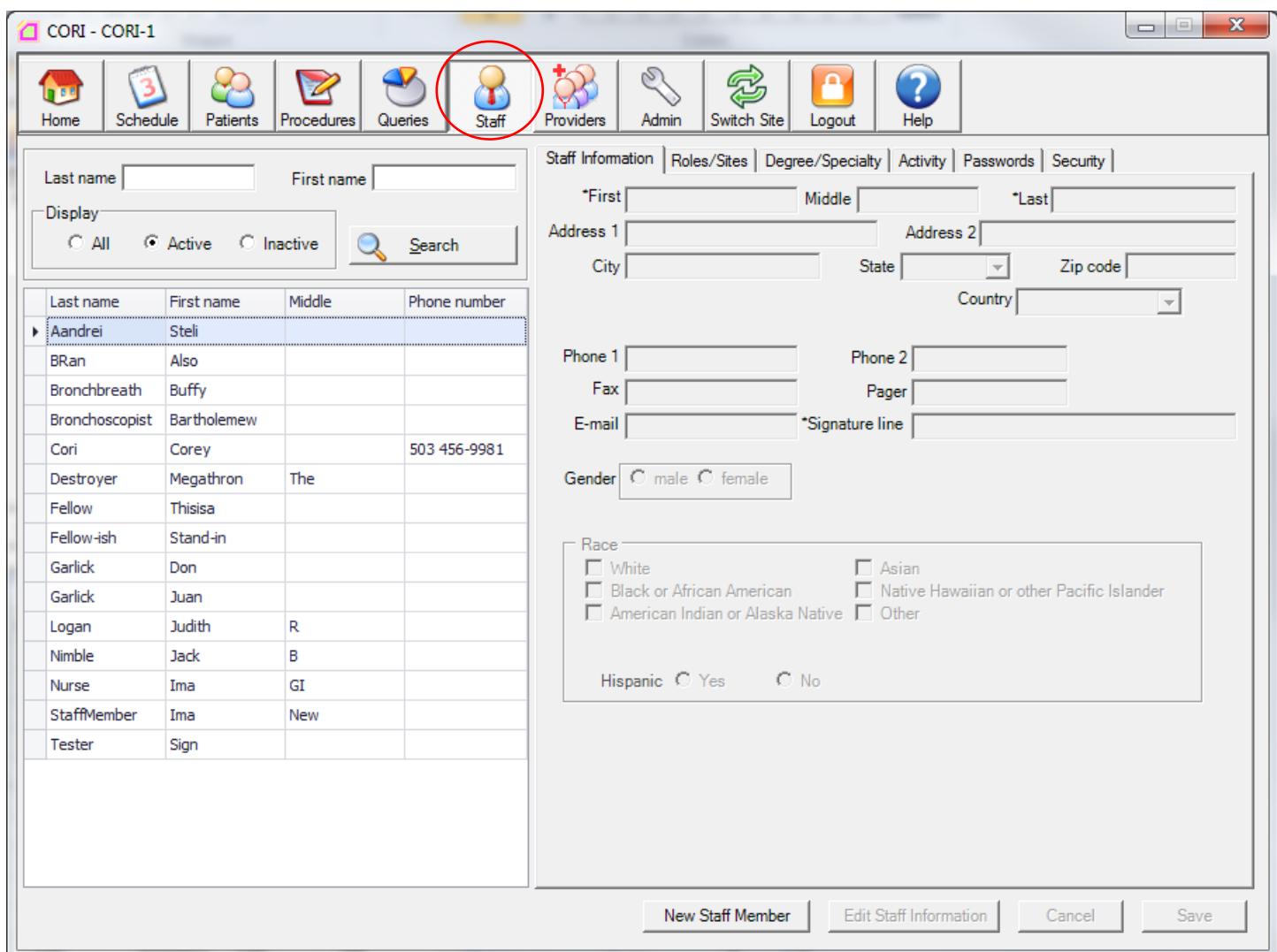
New queries can be requested from CORI, which can be automatically added to CORI v4. Contact CORI Site Services to request additional queries, or click on the [Request a Query to be Added](#) link.

Staff Page

Staff records are required for any person at the practice site who will use CORI v4, or be listed as personnel in a procedure report. Staff records are generally managed by the Site Administrator.

While only the First name, Last name, and Signature line are required to save a staff record, to be useful it must also include a username and password, security permissions, and be set to Active. In addition, records for personnel who will be listed in a procedure must include a staff role (see [Staff Roles](#)) and, if it is an Endoscopist or Bronchoscopist role, a CUEI (see [CORI Unique Endoscopist Identifier – CUEI](#)).

In order for a staff member to be able to sign any part of the procedure report, their staff record must have one of the signing permissions.



Last name	First name	Middle	Phone number
Aandrei	Steli		
BRan	Also		
Bronchbreath	Buffy		
Bronchoscopist	Bartholemew		
Cori	Corey		503 456-9981
Destroyer	Megathron	The	
Fellow	Thisisa		
Fellow-ish	Stand-in		
Garlick	Don		
Garlick	Juan		
Logan	Judith	R	
Nimble	Jack	B	
Nurse	Ima	GI	
StaffMember	Ima	New	
Tester	Sign		

The Staff Page consists of the following areas:

Search Facility: See [Searching Records in CORI v4](#).

Tab Block: Displays the details of the staff record selected in the Search Results. Click on **New Staff Member** or on **Edit Staff Information** to add or change staff information.

Record Management Buttons: These are used to create a new staff record, or edit an existing one.

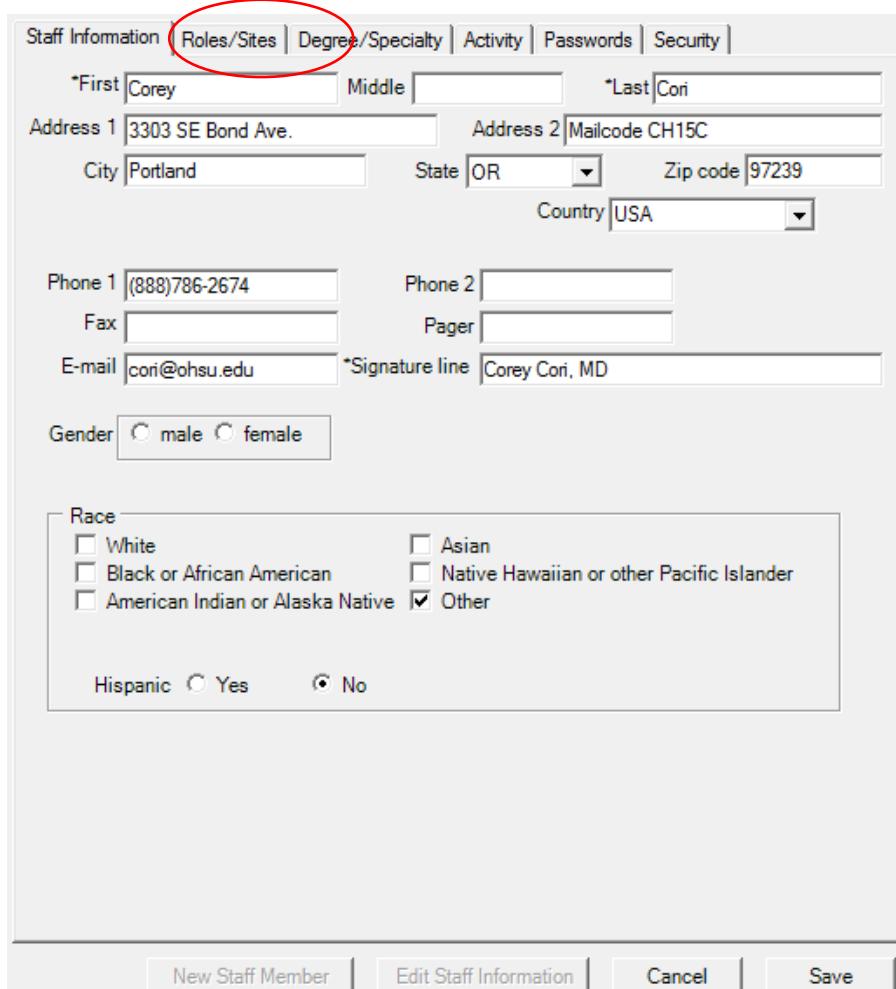
Creating or Editing a Staff Record

1. A search must be performed before a new staff record can be created (see [Searching Records in CORI v4](#)).
2. Click on **New Staff Member** to create a new record or **Edit Staff Information** to edit an existing record.
3. Enter or change information as needed.
4. Click on **Save** to save the record, or on **Cancel** to discard all changes.

Staff Record Tabs

The staff record information is spread over several tabs, each containing specific information. Below are descriptions and images of the tabs.

The Staff Information tab contains basic information about the staff member. The First, Last and Signature line fields are required in order to save the record. Completing the "First" and "Last" fields automatically fills the Signature line field.



Staff Information | Roles/Sites | Degree/Specialty | Activity | Passwords | Security

*First Middle *Last

Address 1 Address 2

City State Zip code

Country

Phone 1 Phone 2
 Fax
 Pager
 E-mail *Signature line

Gender male female

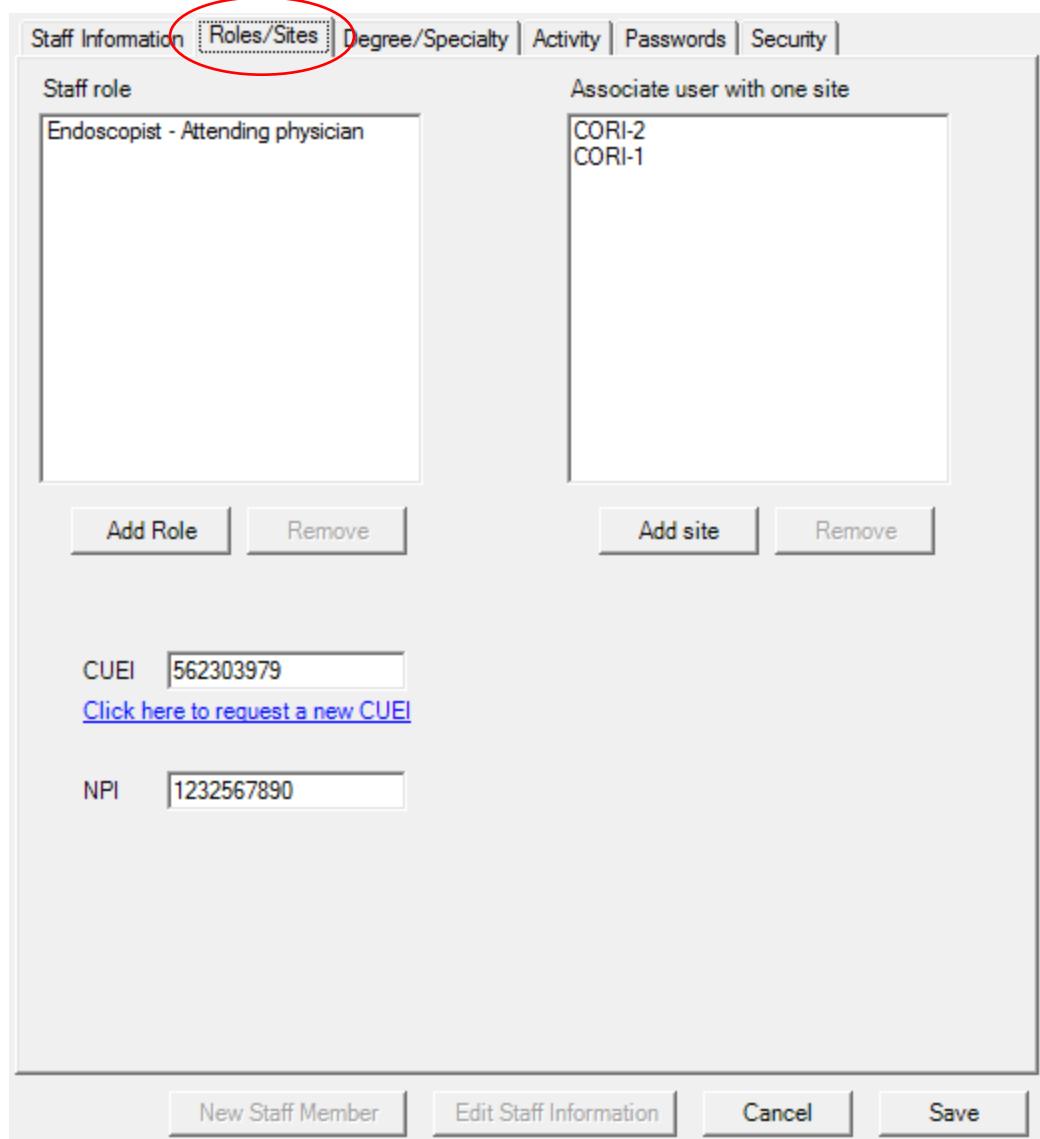
Race

<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> American Indian or Alaska Native	<input checked="" type="checkbox"/> Other

Hispanic Yes No

New Staff Member | Edit Staff Information | Cancel | Save

The Roles/Sites tab contains the staff roles (see [Staff Roles](#)) and associated sites (see [Home Page](#)) lists. The staff role determines how the staff member will appear on a Procedure report.



Staff Information **Roles/Sites** Degree/Specialty | Activity | Passwords | Security |

Staff role

Endoscopist - Attending physician

Associate user with one site

CORI-2
CORI-1

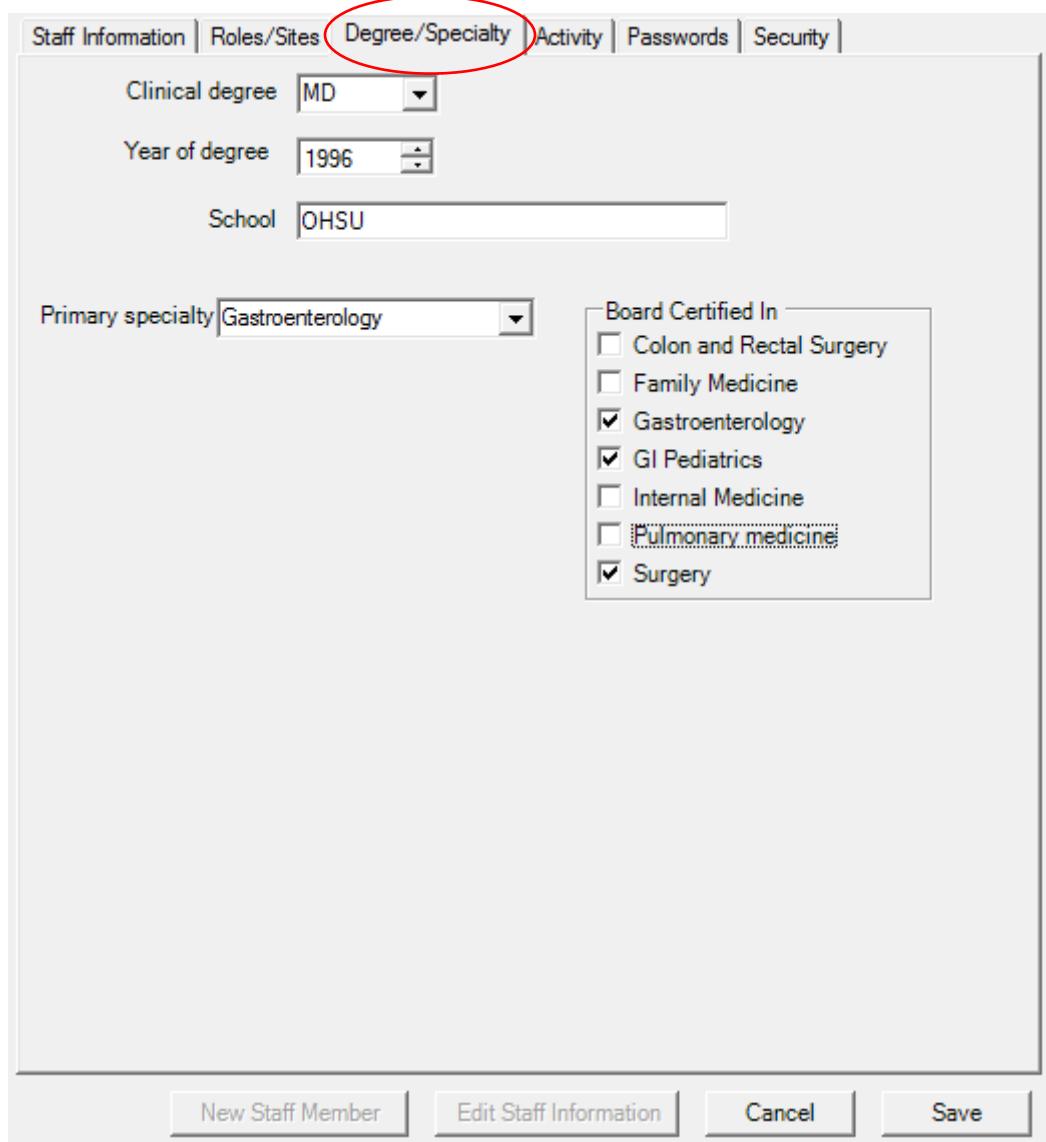
Add Role Remove Add site Remove

CUEI 562303979
[Click here to request a new CUEI](#)

NPI 1232567890

New Staff Member Edit Staff Information Cancel Save

The Degree/Specialty tab displays degree and education information for the staff member. Completing this tab is optional, however completing the Clinical degree field helps automatically fill the Signature line field on the Staff Information tab.



Staff Information | Roles/Sites | **Degree/Specialty** | Activity | Passwords | Security |

Clinical degree: MD

Year of degree: 1996

School: OHSU

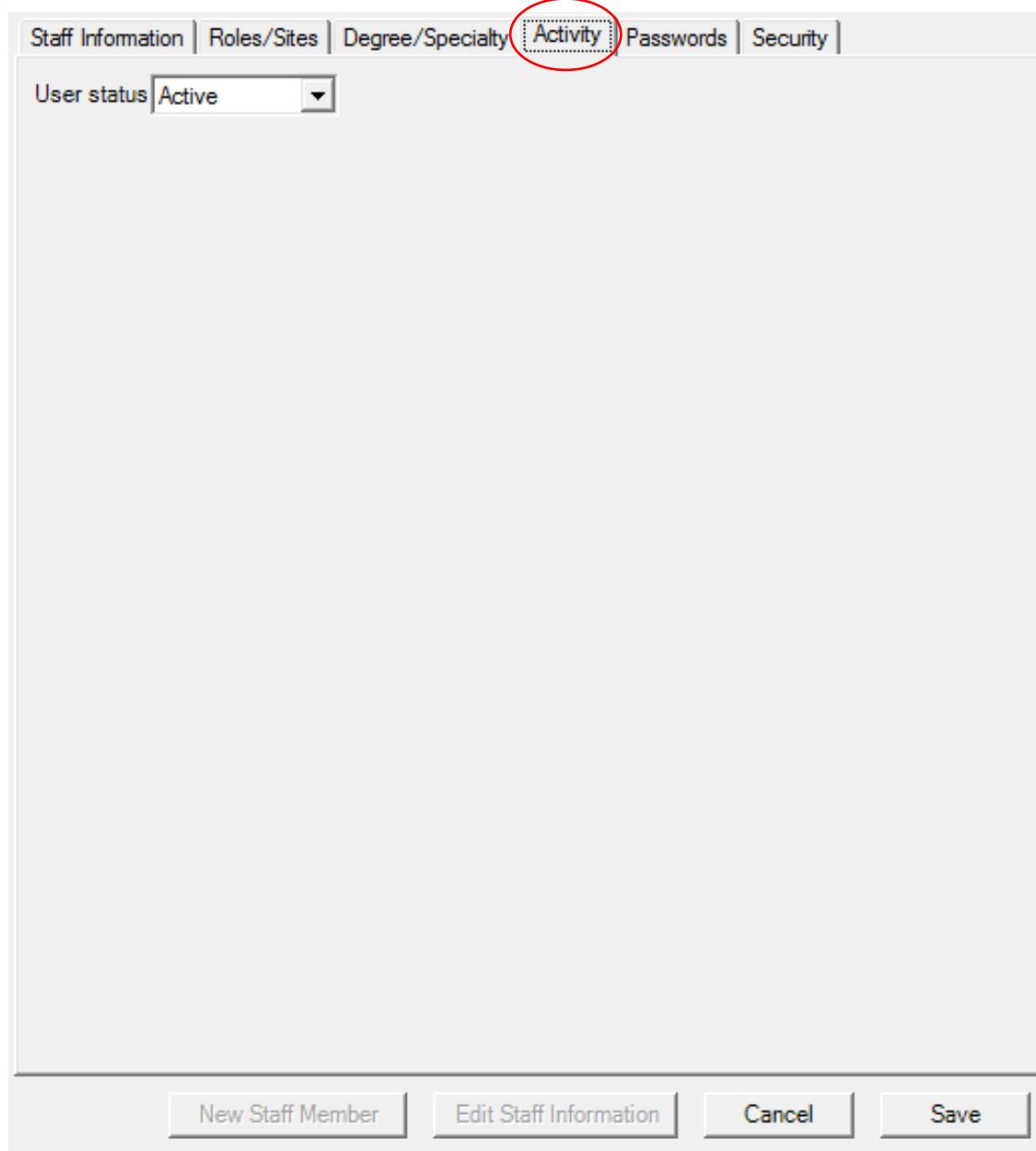
Primary specialty: Gastroenterology

Board Certified In:

- Colon and Rectal Surgery
- Family Medicine
- Gastroenterology
- GI Pediatrics
- Internal Medicine
- Pulmonary medicine
- Surgery

New Staff Member | Edit Staff Information | Cancel | Save

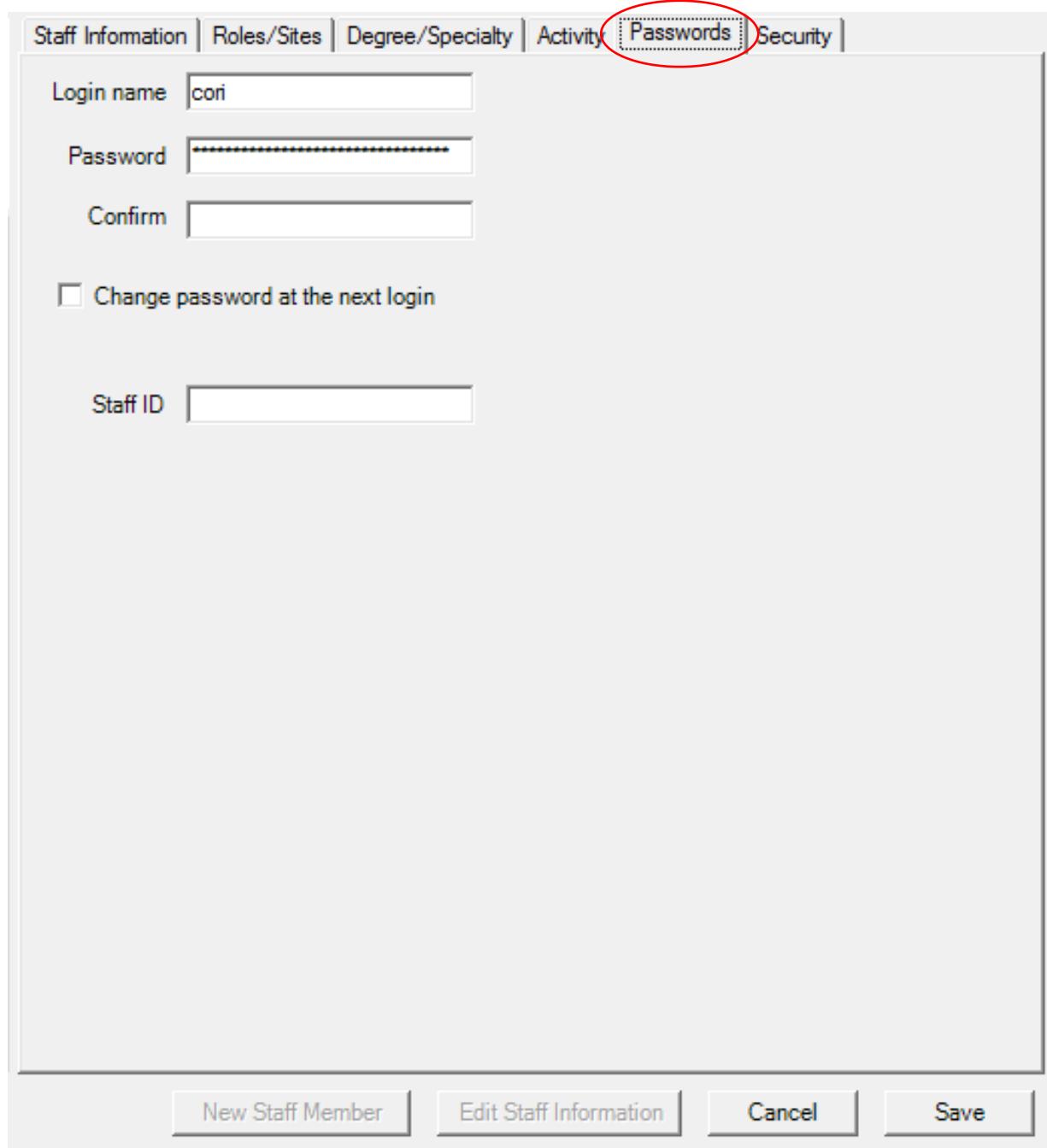
The Activity tab displays the activity status of a staff record. Setting a staff record to Inactive disables staff, and hides record from searches when only active records are searched (see [Active and Inactive Staff Records](#)).



The screenshot shows a software interface for managing staff records. At the top, there is a navigation bar with several tabs: Staff Information, Roles/Sites, Degree/Specialty, **Activity** (which is circled in red), Passwords, and Security. Below the tabs, there is a dropdown menu labeled "User status" with "Active" selected. At the bottom of the screen, there are four buttons: "New Staff Member", "Edit Staff Information", "Cancel", and "Save".

The Passwords tab displays the staff member's username, whether they have a password, and whether the password must be changed at the user's next login. The Site Administrator generally resets passwords from this page.

The Staff ID field is used to associate a unique identifier with a staff record.



Staff Information | Roles/Sites | Degree/Specialty | Activity | **Passwords** | Security |

Login name: cori

Password: *****

Confirm: *****

Change password at the next login

Staff ID: *****

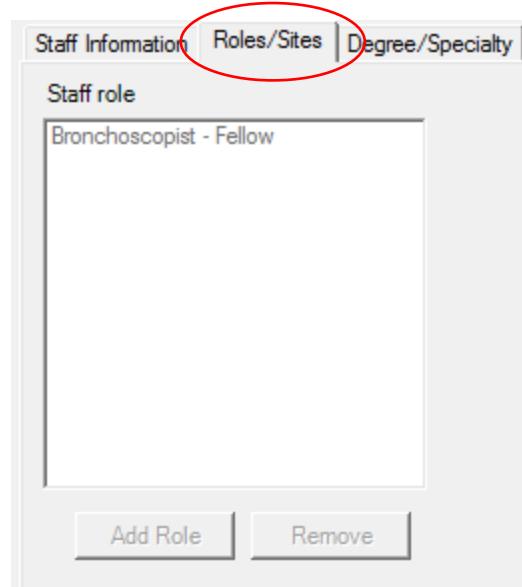
New Staff Member | Edit Staff Information | Cancel | Save

The Security tab displays the security template and security permissions assigned to the staff member (See the CORI v4 Administrator Manual for more information about security templates and permissions).

Staff Information	Roles/Sites	Degree/Specialty	Activity	Passwords	Security						
<table border="1"><thead><tr><th colspan="2">Security Templates</th><th>Permissions</th></tr></thead><tbody><tr><td colspan="2"><ul style="list-style-type: none"><input type="checkbox"/> No Permissions<input type="checkbox"/> Administrator<input type="checkbox"/> Doctor<input type="checkbox"/> jasidj<input type="checkbox"/> Nurse<input type="checkbox"/> Scheduler<input type="checkbox"/> SchedulerView<input checked="" type="checkbox"/> Superuser<input type="checkbox"/> test3</td><td><ul style="list-style-type: none"><input checked="" type="checkbox"/> Add patient<input checked="" type="checkbox"/> Edit patient information<input checked="" type="checkbox"/> Delete patient<input checked="" type="checkbox"/> View patient information<input checked="" type="checkbox"/> Add staff member<input checked="" type="checkbox"/> Edit staff information<input checked="" type="checkbox"/> View staff information<input checked="" type="checkbox"/> Inactivate staff member<input checked="" type="checkbox"/> View inactive staff information<input checked="" type="checkbox"/> Edit own staff information<input checked="" type="checkbox"/> Create procedure<input checked="" type="checkbox"/> Edit unsigned procedure<input checked="" type="checkbox"/> Sign procedures/Edit signed procedures<input checked="" type="checkbox"/> Create and sign addendum<input checked="" type="checkbox"/> View procedure<input checked="" type="checkbox"/> Delete procedure<input checked="" type="checkbox"/> Reassign procedure<input checked="" type="checkbox"/> Emergency access<input checked="" type="checkbox"/> Customize lists (insurance, CPT codes, etc)<input checked="" type="checkbox"/> Create/Edit security templates<input checked="" type="checkbox"/> Set or change permissions of staff<input checked="" type="checkbox"/> Set or change password of staff<input checked="" type="checkbox"/> Change security settings<input checked="" type="checkbox"/> Query data<input checked="" type="checkbox"/> View Schedule<input checked="" type="checkbox"/> Modify schedule</td></tr></tbody></table>						Security Templates		Permissions	<ul style="list-style-type: none"><input type="checkbox"/> No Permissions<input type="checkbox"/> Administrator<input type="checkbox"/> Doctor<input type="checkbox"/> jasidj<input type="checkbox"/> Nurse<input type="checkbox"/> Scheduler<input type="checkbox"/> SchedulerView<input checked="" type="checkbox"/> Superuser<input type="checkbox"/> test3		<ul style="list-style-type: none"><input checked="" type="checkbox"/> Add patient<input checked="" type="checkbox"/> Edit patient information<input checked="" type="checkbox"/> Delete patient<input checked="" type="checkbox"/> View patient information<input checked="" type="checkbox"/> Add staff member<input checked="" type="checkbox"/> Edit staff information<input checked="" type="checkbox"/> View staff information<input checked="" type="checkbox"/> Inactivate staff member<input checked="" type="checkbox"/> View inactive staff information<input checked="" type="checkbox"/> Edit own staff information<input checked="" type="checkbox"/> Create procedure<input checked="" type="checkbox"/> Edit unsigned procedure<input checked="" type="checkbox"/> Sign procedures/Edit signed procedures<input checked="" type="checkbox"/> Create and sign addendum<input checked="" type="checkbox"/> View procedure<input checked="" type="checkbox"/> Delete procedure<input checked="" type="checkbox"/> Reassign procedure<input checked="" type="checkbox"/> Emergency access<input checked="" type="checkbox"/> Customize lists (insurance, CPT codes, etc)<input checked="" type="checkbox"/> Create/Edit security templates<input checked="" type="checkbox"/> Set or change permissions of staff<input checked="" type="checkbox"/> Set or change password of staff<input checked="" type="checkbox"/> Change security settings<input checked="" type="checkbox"/> Query data<input checked="" type="checkbox"/> View Schedule<input checked="" type="checkbox"/> Modify schedule
Security Templates		Permissions									
<ul style="list-style-type: none"><input type="checkbox"/> No Permissions<input type="checkbox"/> Administrator<input type="checkbox"/> Doctor<input type="checkbox"/> jasidj<input type="checkbox"/> Nurse<input type="checkbox"/> Scheduler<input type="checkbox"/> SchedulerView<input checked="" type="checkbox"/> Superuser<input type="checkbox"/> test3		<ul style="list-style-type: none"><input checked="" type="checkbox"/> Add patient<input checked="" type="checkbox"/> Edit patient information<input checked="" type="checkbox"/> Delete patient<input checked="" type="checkbox"/> View patient information<input checked="" type="checkbox"/> Add staff member<input checked="" type="checkbox"/> Edit staff information<input checked="" type="checkbox"/> View staff information<input checked="" type="checkbox"/> Inactivate staff member<input checked="" type="checkbox"/> View inactive staff information<input checked="" type="checkbox"/> Edit own staff information<input checked="" type="checkbox"/> Create procedure<input checked="" type="checkbox"/> Edit unsigned procedure<input checked="" type="checkbox"/> Sign procedures/Edit signed procedures<input checked="" type="checkbox"/> Create and sign addendum<input checked="" type="checkbox"/> View procedure<input checked="" type="checkbox"/> Delete procedure<input checked="" type="checkbox"/> Reassign procedure<input checked="" type="checkbox"/> Emergency access<input checked="" type="checkbox"/> Customize lists (insurance, CPT codes, etc)<input checked="" type="checkbox"/> Create/Edit security templates<input checked="" type="checkbox"/> Set or change permissions of staff<input checked="" type="checkbox"/> Set or change password of staff<input checked="" type="checkbox"/> Change security settings<input checked="" type="checkbox"/> Query data<input checked="" type="checkbox"/> View Schedule<input checked="" type="checkbox"/> Modify schedule									
New Staff Member	Edit Staff Information	Cancel	Save								

Staff Roles

Users that will be listed in a procedure record must have a staff role. It is not required for users who will not be listed. Endoscopists and Bronchoscopists must have a staff role in their record to be listed and identified as a Responsible Endoscopist / Bronchoscopist. There are over 25 staff roles that can be used to identify a staff member in a procedure record.



CORI Unique Endoscopist Identifier – CUEI

In order to uniquely identify doctors in CORI v4 who perform procedures, their staff record must contain a CUEI. This is required for any staff record that has an Endoscopist or Bronchoscopist staff role. A CUEI can be requested from CORI by clicking the [Click here to request a new CUEI](#) link in the Roles/Sites tab or by completing the CUEI Request Form on the CORI website ([CUEI Website Request Form](#)). This is usually handled by the Site Administrator.

Active and Inactive Staff Records

Because staff records are associated with procedure records, staff record cannot be deleted when a person is no longer employed at the practice site. Deleting a staff record would change the data for a procedure record signed in the past.

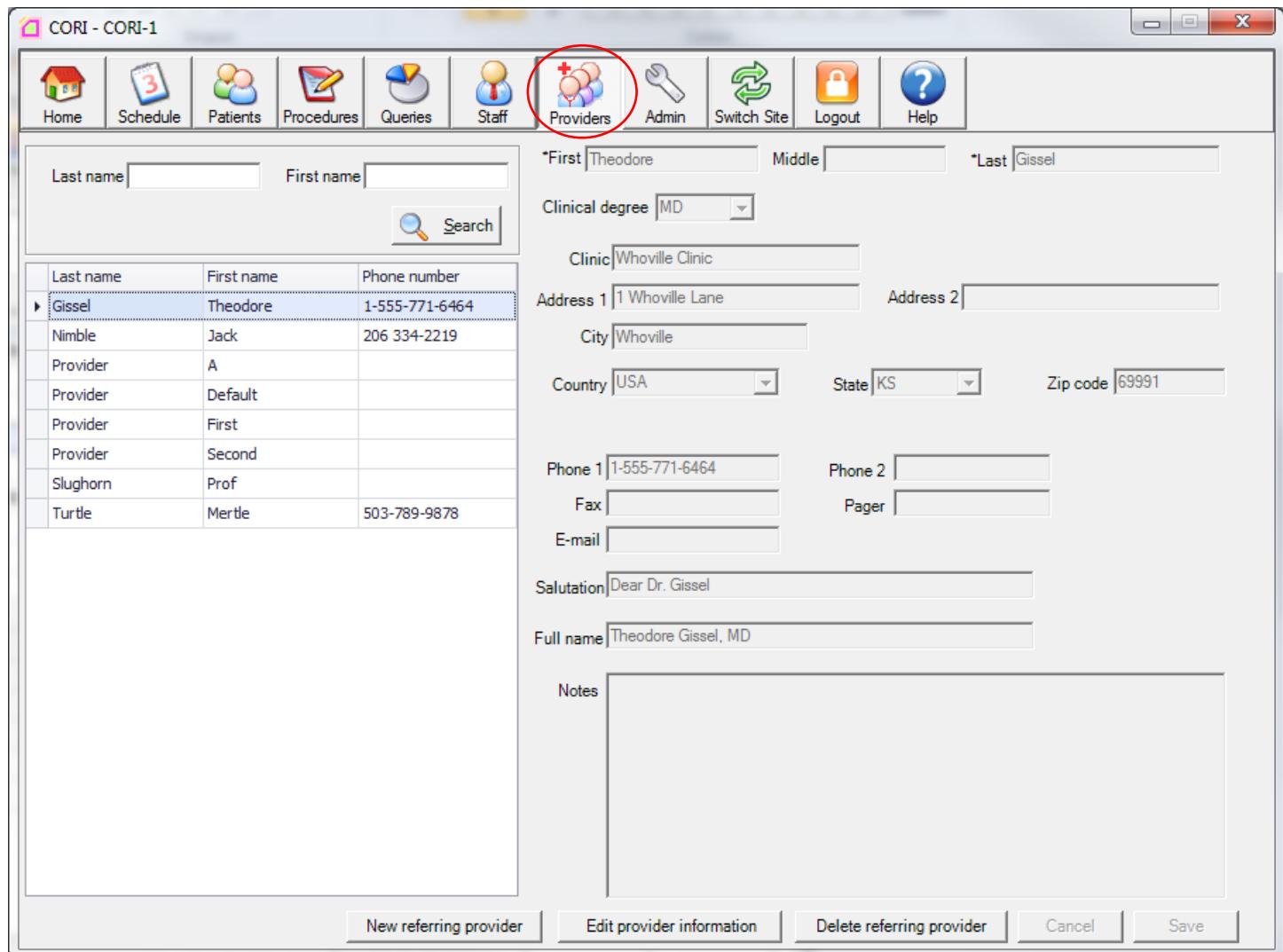
Instead, a staff record for an ex-employee is designated as inactive, and will not appear in the Procedure personnel table in the Preprocedure section of a procedure record.

Users with the 'View inactive staff' permission see an option group in the Staff Page search area, which allows a staff record search to be limited to active staff, inactive staff, or both.

Last name	<input type="text"/>	First name	<input type="text"/>
Display		<input type="radio"/> All <input checked="" type="radio"/> Active <input type="radio"/> Inactive	
<input type="button" value="Search"/>			

Referring Providers Page

The Referring Providers Page is used for managing provider records. A referring provider is anyone designated to receive a copy of the procedure report (e.g. a referring physician). Referring provider records are used for generating referral letters, and in conjunction with the automatic faxing feature of CORI v4.



The screenshot shows the CORI v4.2.3.0 User Manual interface. The top menu bar includes Home, Schedule, Patients, Procedures, Queries, Staff, Providers (circled in red), Admin, Switch Site, Logout, and Help. The main content area has search fields for Last name and First name, and a search button. Below these are fields for Middle name, Clinical degree (MD), Clinic (Whoville Clinic), Address 1 (1 Whoville Lane), Address 2, City (Whoville), Country (USA), State (KS), Zip code (69991), Phone 1 (1-555-771-6464), Phone 2, Fax, Pager, E-mail, Salutation (Dear Dr. Gissel), and Full name (Theodore Gissel, MD). A Notes section is also present. At the bottom are buttons for New referring provider, Edit provider information, Delete referring provider, Cancel, and Save.

Last name	First name	Phone number
Gissel	Theodore	1-555-771-6464
Nimble	Jack	206 334-2219
Provider	A	
Provider	Default	
Provider	First	
Provider	Second	
Slughorn	Prof	
Turtle	Mertle	503-789-9878

NOTE: There is no correlation between the staff and referring provider records in CORI v4. If a person has a staff record, they still need a provider record in order to have procedure reports and referral letters generated for them, either for printing or via fax.

Creating a Referring Provider

Most referring provider information is optional though first and last names are required. Completing these and the clinical degree field automatically fills the salutation and full name fields. These fields are highly recommended, as their contents appear in the procedure report and the referral letters. The fax field must be completed in order to use the automatic faxing feature (if available).

1. A search must be performed before a new Provider record can be created (see [Searching Records in CORI v4](#)).
2. Click .
3. Enter the referring provider information.
4. Click to save the record, or to discard it.

Editing an Existing Provider Record

1. Search for the desired provider record (see [Searching Records in CORI v4](#)).
2. Click the desired row to select the record.
3. Click .
4. Edit the provider information as needed.
5. Click to save changes to the record or to discard them.

Deleting a Provider Record

1. Search for the desired provider record (see [Searching Records in CORI v4](#)).
2. Click the desired row to select the record.
3. Click .
4. Click in the confirmation dialog to delete the record or to keep it.

Procedure Module

The Procedure Module is where the procedure is actually documented in CORI v4. The navigation bar on the left is used to access the individual procedure sections, in which data is entered into required and non-required fields. Once the procedure record is complete, the report is electronically signed, viewed, and printed from this window.

[History](#)

[Physical exam](#)

[Liver Disease](#)

[Indications](#)

[Preprocedure](#)

[Sedation](#)

[Procedure](#)

[COL Findings](#)

[Sm. Bowel Findings](#)

[Events](#)

[Assessment/Plan](#)

[Letters/Instructions](#)

[Save](#)

[Sign](#)

[Print Preview](#)

[Close](#)

[Pathology](#)

[Images](#)

[Print](#)

[Fax](#)

[Orders](#)

Medications

Within the last 7 days, has the patient taken anti-inflammatory, anti-coagulant or anti-platelet medications?

Yes No

Which medications	Stopped prior to exam?	# of days prior
<input type="checkbox"/> ASA	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> NSAID	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> COX-2	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Heparin	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> LMWH	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Coumadin	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Plavix	<input type="radio"/> Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Other	<input type="radio"/> Yes <input checked="" type="radio"/> No	

Other antiinflammatory/anticoagulant/antiplatelet meds

Anticoagulation plan

Other medications

Patient habits

Smoking history

Amount *

Does not smoke every day

Number of years

Current alcohol consumption (wine, beer, liquor)

No prior surgeries

Surgical history ►

No history of major medical illness

Medical history ►

Recent labs/studies

Yes No

Allergies

Yes No

History comments

Please do not use this field if you can document the information using other fields on the screen

Procedure records must be created from the Patients or Schedule Pages. For more information on creating procedure records, see [Creating a Procedure Record](#) or [Creating a Procedure Record from an Appointment](#).

Existing procedure records may be accessed from the Patients and Procedures Pages. See [Patients Page](#) and [Procedures Page](#)).

Procedure Navigation Bar

Click the buttons along the left side of the Procedure window to access the different procedure sections.

Clinical Outcomes Research Initiative

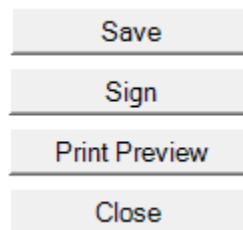
www.cori.org

Page 40 of 100

Report Management Buttons

Farther down the left side of the Procedure window are buttons used to manage the procedure record.

Click on **Save** to save the procedure record as a work-in-progress. Procedure records may be saved at any time, until they are electronically signed. Once the report has been signed the *Save* button becomes disabled.

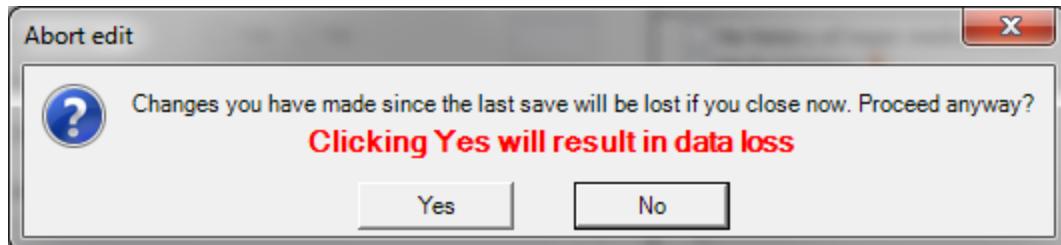


Click **Sign** to electronically sign the procedure. See [Signing a Procedure](#).

Click **Print Preview** to display a preview of the unsigned procedure report. Although the report can be printed from the Preview window, it contains a "Preliminary Report" watermark and is not suitable as a legal record.

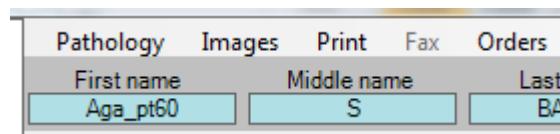
Once the report has been signed this button changes to **Print**, providing more options. See [Printing, Faxing and Previewing a Procedure report](#) and [Previous Report Versions](#) for more information on printing signed reports.

Click **Close** to exit the Procedure window and return to the Main window. If changes have been made to the report since it was last saved or signed, a warning dialog will appear asking for confirmation to close the window.



Procedure Menus

The menus at the top of the Procedure window provide access to data external to the report. In addition, documents produced in CORI v4 can be previewed and faxed from these menus.



Pathology menu

Use the Pathology menu to create a requisition for pathology samples if using a cooperating pathology company, or import pathology reports into the current procedure report (see [Importing and Exporting from CORI v4](#)). Once imported, the pathology report can be viewed or deleted using this menu.

Images menu

Use the Images menu to import images into the current procedure record (see [Importing and Exporting from CORI v4](#)). Imported images can also be deleted using this menu.

Print menu

Use the Print menu to preview the procedure report, imported pathology reports (if any), the patient instruction handout, and the letter to the referring provider (also see [Printing, Faxing and Previewing a Procedure](#)).

It is possible to copy a PDF of the report and paste it into any Windows program. Select "Copy Report to Clipboard" to copy the text of the procedure report to the clipboard, from where it can be pasted into any Windows program.

If it has been configured, select Copy Chart Label to Clipboard to copy the chart label text to the clipboard, from where it can be pasted into any Windows program.

Fax menu

Use the Fax menu to fax the Procedure report and referral letter, or an imported pathology report, to a provider (see Providers Page). Any provider can be selected as a recipient, whether or not they've been selected in the Letters/Instructions Section. (See [Printing, Faxing and Previewing a Procedure](#))

To fax to a referring provider:

1. Select the menu entry corresponding to the document to be faxed. The appropriate Fax screen appears:
2. In the screen that appears, begin typing the last name of the desired provider into the text box below "Choose a Provider to send Fax to." The list of providers narrows as more letters are typed.
3. Click the desired provider.
4. In the Pathology Report Fax Screen, select the desired pathology report (if there is more than one) from the Pathology reports dropdown list.
5. Click .

Procedure Field Types

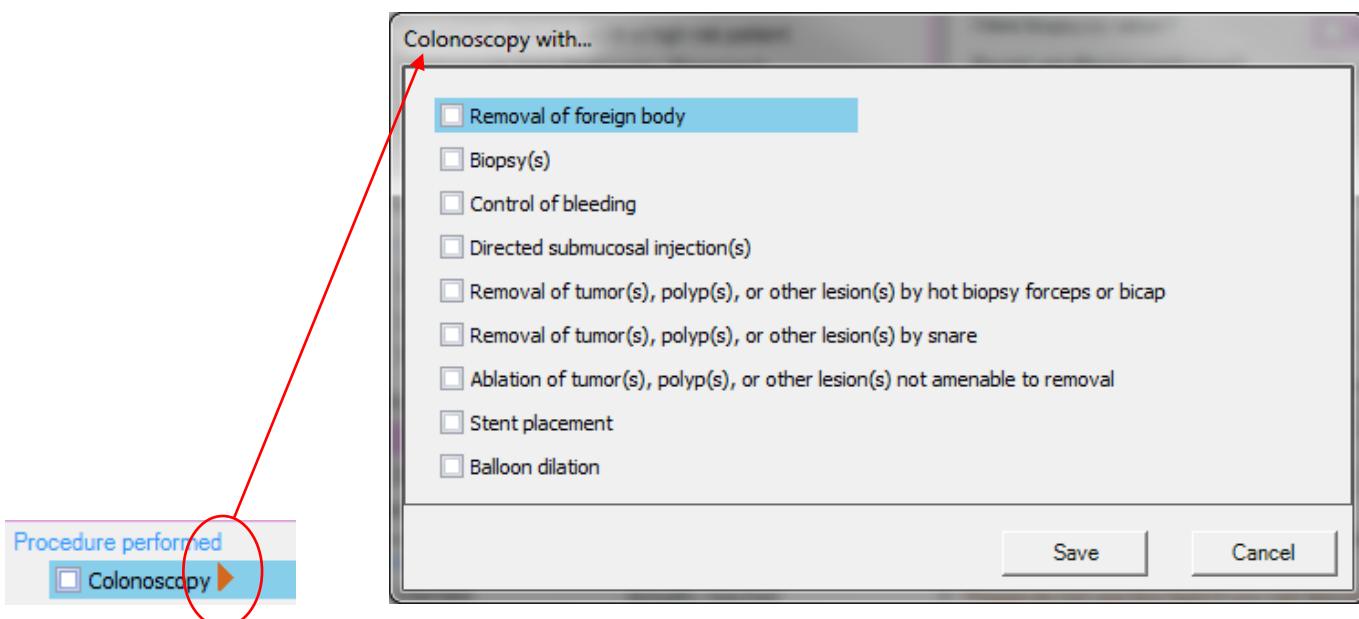
Throughout the procedure sections, different fields are used to enter information. Each field is designed for adding information to the report in a specific way, while preventing clutter. Fields common to most Windows applications are not addressed here – only fields unique to CORI v4.

NOTE: The Procedure window has several fields that are required to be filled out before a Procedure can be signed. These fields are highlighted in purple like this  and must be filled out before a procedure can be completed in CORI.

Simple Checkbox: a stylized version of the standard Windows checkbox. To clear the checkbox, right click on it.



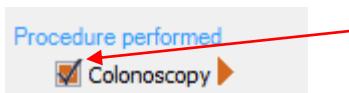
Flag Checkbox: combines a checkbox with the ability to add more detailed information. Clicking in the checkbox, on the text, or on the orange arrow (the “flag”) displays a detail screen.

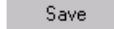


If no information is entered in the detail screen, the checkbox displays a black checkmark with a white background. Selecting the checkbox again removes the checkmark.



If information is entered into the detail screen and saved, the checkbox displays a white checkbox with an orange background. Clicking on the field in this state displays the detail screen again.



To clear a flag checkbox, remove all information from the underlying detail screen, and click . The checkbox reverts to black-on-white, and can be selected again to clear it.

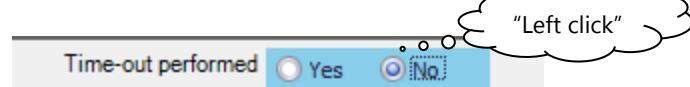
Option Group: composed of two or more circles (options), each with associated text. Option groups exist in other Windows applications, but are modified for use in CORI v4.



Clicking one of the options selects its associated choice:



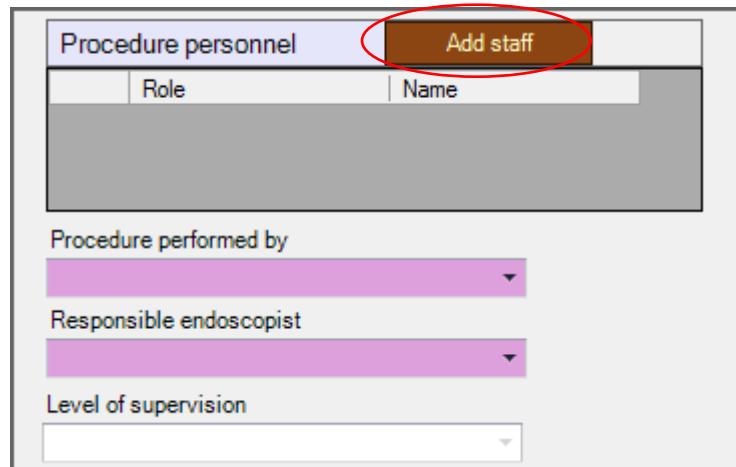
Clicking a different option selects its associated choice, and clears the original choice:



In CORI v4 there may be a reason to clear the option group entirely (for example, when a selection has been made inadvertently). To do this, right-click in the selected option:



Table: a field for adding rows of specific data to a list. The box in the upper-left corner indicates the information the grid contains, and the name of each column indicates the type of data intended for the cells in that column.



Click on **Add** to create a new row in the table. The leftmost cell's dropdown list is opened, showing items available for selection.

Procedure personnel		Add staff
	Role	Name
▶	Bronchoscopist - Attending physician	
	Bronchoscopist - Fellow	
	Endoscopist - Attending physician	
Procedure	Endoscopist - Fellow	
	Nurse	
	Nurse anesthetist	
Respon	Nurse assistant	
	Nurse practitioner	

Enter data into each cell to complete the row.

Procedure personnel		Add staff
	Role	Name
▶	Bronchoscopist - Attending physician	Steli Aandrei
		Steli Aandrei
		Bartholemew Bronchoscopist
		Don Garlick
Procedure performed by		

To select a different entry for the first cell, open its dropdown list and select another item. The entry in a cell determines the choices available in the next cell.

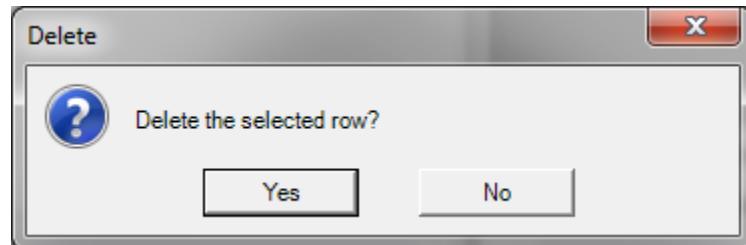
Procedure personnel		Add staff
	Role	Name
▶	Nurse	Ima G. Nurse
		Bronchoscopist - Attending physician
		Bronchoscopist - Fellow
Procedure		Endoscopist - Attending physician
		Endoscopist - Fellow
		Nurse
		Nurse anesthetist
Respon		Nurse assistant

Procedure personnel		Add staff
	Role	Name
▶	Nurse	Ima G. Nurse
		Ima G. Nurse
Procedure performed by		
Responsible endoscopist		

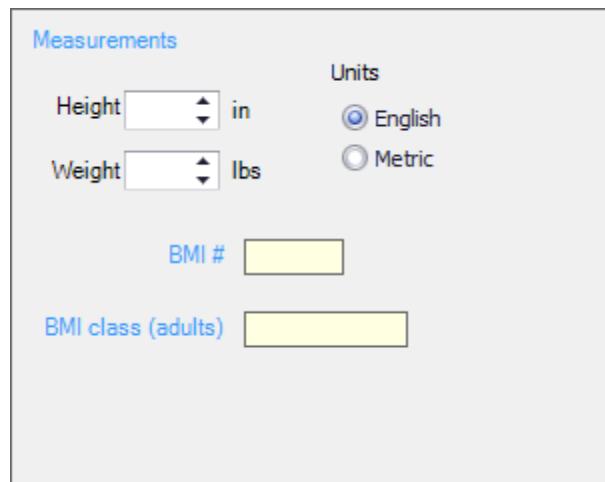
There are several different methods for entering data into a cell. Text boxes, larger text areas, and pop-up calendars are some options. Some dropdown list cells allow typing directly into the cell.

Sedation medications		Add med	
	Medication	Dose	Route
▶	Cetacaine		
		1 spray(s)	
		2 spray(s)	
		3 spray(s)	
		4 spray(s)	
		5 spray(s)	

To delete a row from the data grid, highlight the row by clicking the gray rectangle at the left, and press the Delete key. A dialog appears asking for confirmation. Click on **Yes** to delete the row or on **No** to keep it.



BMI Calculator



The screenshot shows a 'Measurements' section with the following fields:

- Height:** A text input field with a dropdown arrow, followed by 'in'.
- Weight:** A text input field with a dropdown arrow, followed by 'lbs'.
- Units:** A group of radio buttons. 'English' is selected (radio button is checked). 'Metric' is also an option.
- BMI #:** A text input field.
- BMI class (adults):** A text input field.

The BMI calculator in the Physical Exam Section automatically calculates the BMI and adult BMI class. Enter information into the Height and Weight fields in the calculator, and click away from the fields. The BMI and class are calculated and displayed in the indicated fields.

The Measurement Units option group allows switching between English and Metric units for height and weight. Doing so causes the Height and Weight fields to convert to the proper units. Note that repeatedly switching between English and Metric may introduce small changes into these fields as the calculations introduce rounding errors.

Be sure the height and weight values correspond to the Measurement Units selection. This selection is saved along with the procedure record.

Active Defaults

Active Defaults allow users to complete several fields in a procedure section with a single mouse-click. Users can create their own set of Active Defaults for each procedure type.

- Active Defaults only exist in the Preprocedure, Procedure and Letters/Instructions Sections.
- Required controls cannot be defaulted using Active Defaults.
- Controls set by Active Defaults can be changed as needed, and can be re-saved as defaults if desired.

To use Active Defaults:

1. Select the desired values for any non-required fields. In tables, complete as many rows as desired. Individual columns within a row do not need to be completed. Thus, it is possible, for example, to create a row in the Sedation Medication table in the Preprocedure Section, but leave the "Dose" column blank.
2. Click on **Save as Default** in the lower right corner to save the Active Defaults for the section.

3. In subsequent procedures of the same type, click **Use Defaults** (usually in the upper left corner of the procedure section) to apply the defaults.

Defaults are not necessarily meant to be used by more than one person. For example, if a nurse creates a procedure record and uses Active Defaults to complete parts of the procedure sections, a doctor who will complete the procedure should not necessarily use Active Defaults to apply more information to the same section. The doctor's defaults may in some cases negate the settings entered by the nurse's defaults.

It is possible however, through careful coordination, to construct a set of defaults that minimizes mouse activity for everyone involved.

Preprocedure Section

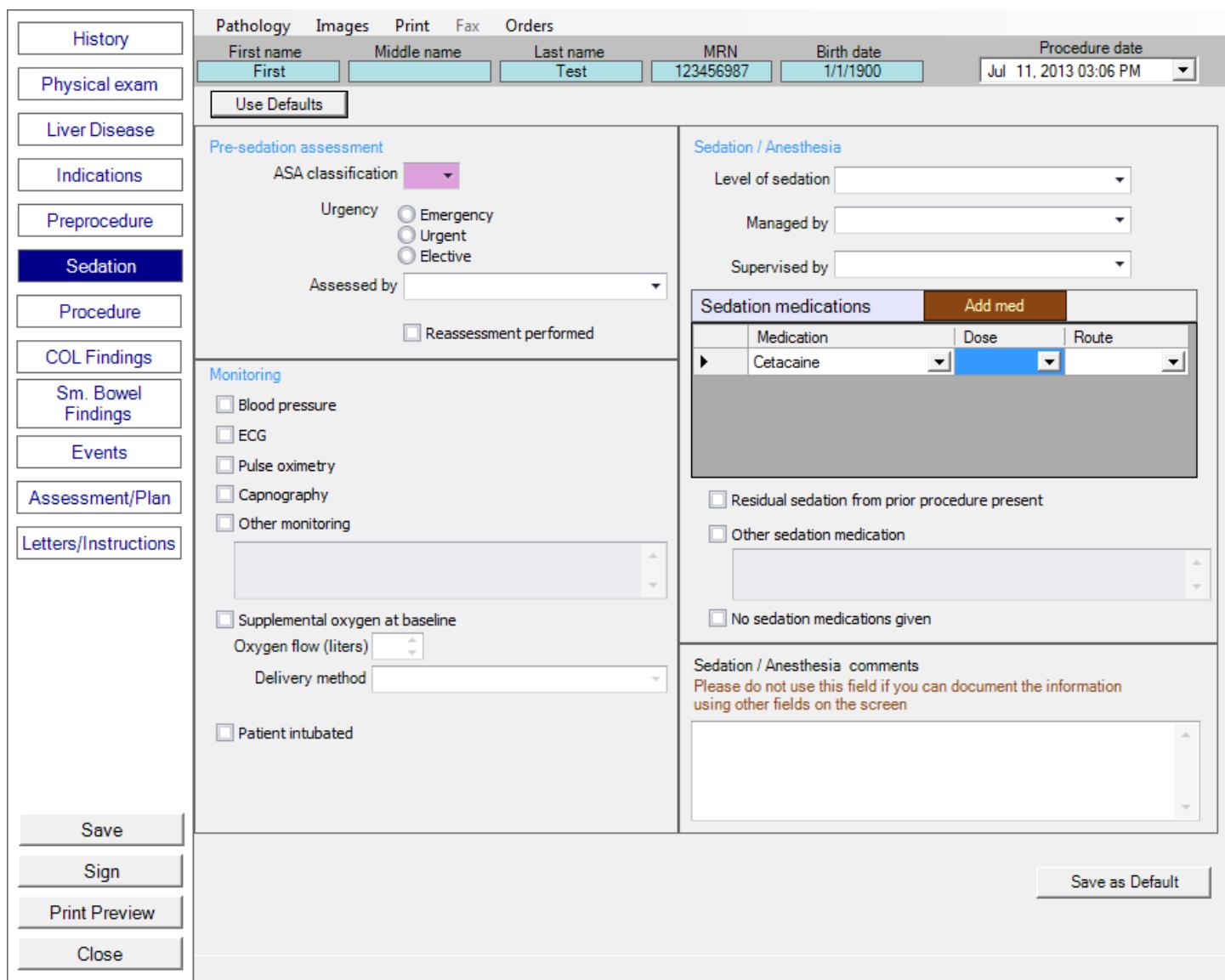
The Preprocedure section can be filled out before a procedure is performed. The required fields in this section are consent and procedure personnel.

Pathology Images Print Fax Orders First name Middle name Last name MRN Birth date Procedure date First Middle Last 123456987 1/1/1900 Jul 11, 2013 03:06 PM													
History Physical exam Liver Disease Indications Preprocedure Sedation Procedure COL Findings Sm. Bowel Findings Events Assessment/Plan Letters/Instructions Save Sign Print Preview Close	<input type="button" value="Use Defaults"/>			<input type="button" value="Save as Default"/>									
	Procedure consent												
	Was a consent obtained? <input checked="" type="radio"/> Yes <input type="radio"/> No												
	Person consenting <input type="text"/>												
	Consent obtained by <input type="text"/>												
	Time-out performed <input checked="" type="radio"/> Yes <input type="radio"/> No												
	Patient Admission Status												
	<input type="radio"/> Outpatient		Endoscopy performed in <input type="text"/>										
	<input type="radio"/> Inpatient												
	<input type="radio"/> ED												
Did the patient consent to be contacted for research purposes? <input type="text"/>													
Procedure personnel													
<input type="button" value="Add staff"/>													
<table border="1"> <thead> <tr> <th>Role</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td colspan="2"> <input type="text"/> </td> </tr> </tbody> </table>						Role	Name	<input type="text"/>					
Role	Name												
<input type="text"/>													
Procedure performed by													
<input type="text"/>													
Responsible endoscopist													
<input type="text"/>													
Level of supervision													
<input type="text"/>													
GI preparation													
Prep used <input type="text"/>													
Prep dose <input type="text"/>													
Over # hours <input type="text"/>													
Preprocedure antibiotics													
<table border="1"> <thead> <tr> <th>Antibiotics</th> <th>Add med</th> </tr> </thead> <tbody> <tr> <td>Medication</td> <td>Dose</td> </tr> <tr> <td></td> <td>Route</td> </tr> <tr> <td colspan="2"> <input type="text"/> </td> </tr> </tbody> </table>						Antibiotics	Add med	Medication	Dose		Route	<input type="text"/>	
Antibiotics	Add med												
Medication	Dose												
	Route												
<input type="text"/>													
<input type="checkbox"/> Other preprocedure antibiotic <input type="text"/>													
Indication for preprocedure antibiotics													
<input type="checkbox"/> Cirrhosis and ascites <input type="checkbox"/> Congenital cardiac malformation <input type="checkbox"/> History of endocarditis <input type="checkbox"/> Hypertrophic cardiomyopathy <input type="checkbox"/> Immuno-compromised <input type="checkbox"/> Mitral valve prolapse with insufficiency <input type="checkbox"/> Obstructed bile duct <input type="checkbox"/> Pancreatic pseudocyst <input type="checkbox"/> Prosthetic valve <input type="checkbox"/> Rheumatic valvular dysfunction <input type="checkbox"/> Systemic pulmonary shunt <input type="checkbox"/> Synthetic vascular graft (<1 year old) <input type="checkbox"/> Other													
Preprocedure comments <small>Please do not use this field if you can document the information using other fields on the screen</small>													
<input type="text"/>													

In this example of the Preprocedure section, the required area is highlighted purple.

Sedation Section

The Sedation section contains pre-sedation assessment, monitoring, and the sedation medications (if used).



Pathology Images Print Fax Orders

First name Middle name Last name MRN Birth date Procedure date

First Test 123456987 1/1/1900 Jul 11, 2013 03:06 PM

Use Defaults

Pre-sedation assessment

ASA classification

Urgency: Emergency, Urgent, Elective

Assessed by

Reassessment performed

Sedation / Anesthesia

Level of sedation

Managed by

Supervised by

Sedation medications

Medication	Dose	Route
Cetacaine		

Residual sedation from prior procedure present

Other sedation medication

No sedation medications given

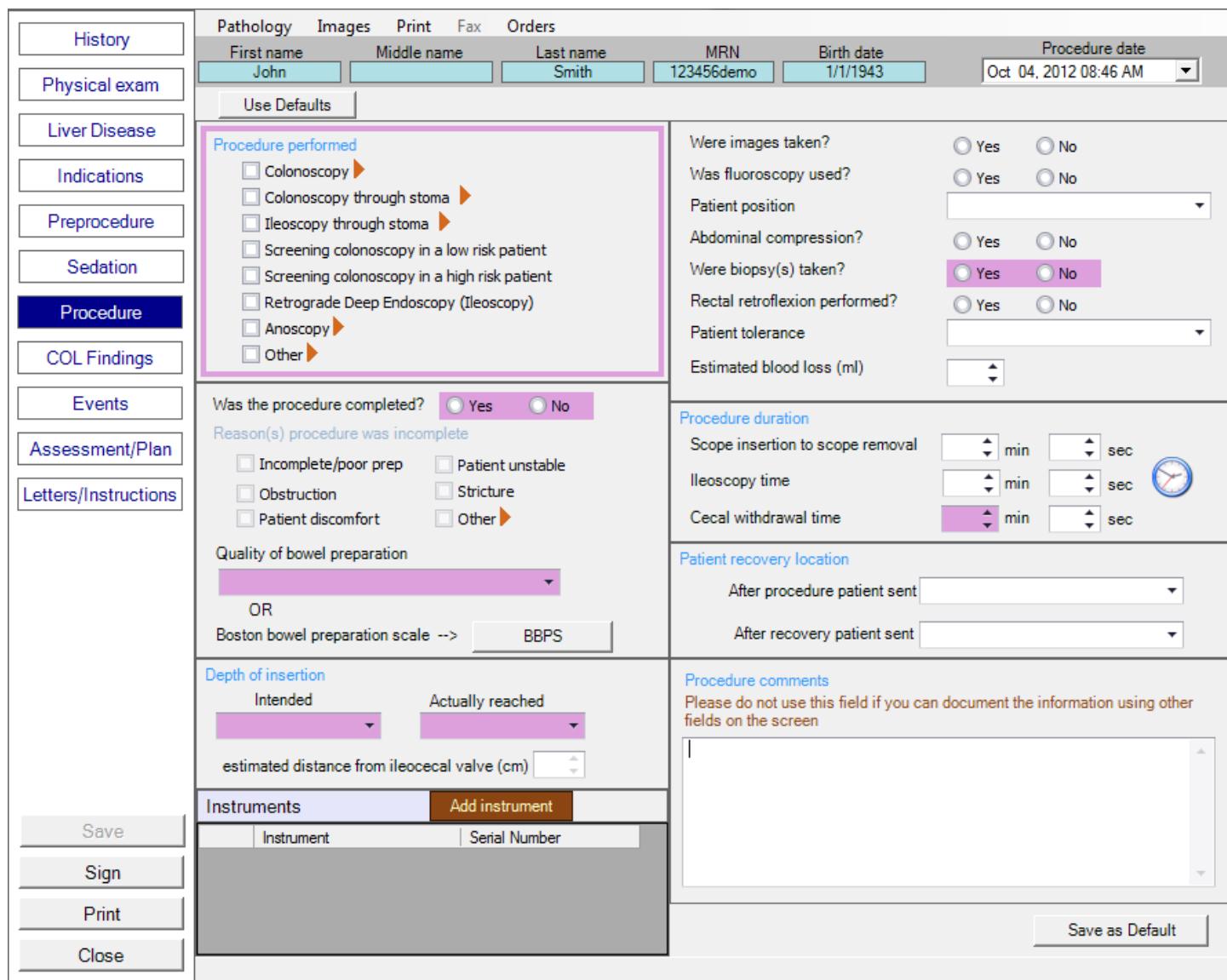
Sedation / Anesthesia comments
Please do not use this field if you can document the information using other fields on the screen

Save as Default

In this example of the Sedation section, the required area is highlighted purple.

Procedure Section

The Procedure section is where you enter metrics and tools used in the procedure. Usually this section is filled out after the procedure has been performed. Here you are required to record what type of procedure was done, if it was completed, the quality of bowel preparation, depth of insertions, instruments and if a biopsy was taken. You can also record the duration of the procedure, and patient recovery location, although the program does not require you to do so.



The screenshot shows the CORI v4 Procedure window. The left sidebar contains buttons for History, Physical exam, Liver Disease, Indications, Preprocedure, Sedation, Procedure (which is selected and highlighted in blue), COL Findings, Events, Assessment/Plan, and Letters/Instructions. The main window has a header with Pathology, Images, Print, Fax, and Orders tabs, and fields for First name (John), Middle name, Last name (Smith), MRN (123456demo), Birth date (1/1/1943), and Procedure date (Oct 04, 2012 08:46 AM). Below the header are buttons for Use Defaults and Procedure performed. The Procedure performed section is highlighted in purple and contains checkboxes for Colonoscopy, Colonoscopy through stoma, Ileoscopy through stoma, Screening colonoscopy in a low risk patient, Screening colonoscopy in a high risk patient, Retrograde Deep Endoscopy (Ileoscopy), Anoscopy, and Other. To the right of this section are fields for Were images taken? (Yes/No), Was fluoroscopy used? (Yes/No), Patient position (dropdown), Abdominal compression? (Yes/No), Were biopsy(s) taken? (Yes/No, with 'Yes' selected), Rectal retroflexion performed? (Yes/No), Patient tolerance (dropdown), and Estimated blood loss (ml) (dropdown). Below these are sections for Procedure duration (Scope insertion to scope removal, Ileoscopy time, Cecal withdrawal time, all with dropdowns and a clock icon), Patient recovery location (After procedure patient sent, After recovery patient sent, both with dropdowns), and Procedure comments (a large text area with a note: 'Please do not use this field if you can document the information using other fields on the screen'). At the bottom are buttons for Save, Sign, Print, Close, and Save as Default.

In this example of the Procedure tab, the required areas is highlighted purple.

Certain sections in the CORI v4 Procedure window contain areas that differ from the standard or CORI v4-specific fields. This chapter discusses procedure sections that have different functionality.

Findings Section

Most procedure types include at least one Findings Section. The diagram in this section allows a graphic representation of a finding's location to be shown on the procedure report.

A typical Finding Section is shown below. In this case, a diagram of the colon is shown as part of a Colonoscopy procedure type. Appropriate diagrams are displayed for different procedure types.

History

Physical exam

Liver Disease

Indications

Preprocedure

Sedation

Procedure

COL Findings

Sm. Bowel Findings

Events

Assessment/Plan

Letters/Instructions

Pathology
Images
Print
Fax
Orders

First name

Middle name

Last name

MRN

Birth date

Procedure date

First

Test

123456987

1/1/1900

Jul 11, 2013 03:06 PM

▼

Colon Findings
Import Images
Multiple findings of ▼
End multiple findings

Cecal landmarks

Appendiceal orifice

Visualized
 Image(s) taken

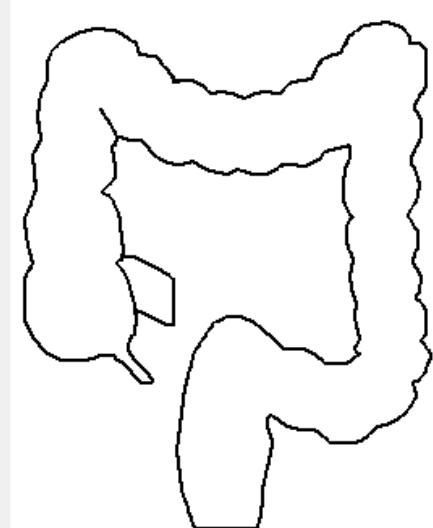
Ileocecal valve

Visualized
 Image(s) taken

Terminal ileum

Visualized
 Image(s) taken

Cecal landmark comments
▶



Normal findings

Entire colon normal

Were any of the following NOT SEEN on the exam?

AVM

Crohn's / Colitis

Diverticulosis / Diverticulitis

Hemorrhoids

Melanosis

Polyp / Tumor

Findings Instructions

Add a Finding: left click the diagram, or left click and drag to shade a region
Delete a Finding: right click on the finding label
View/Edit Details: double click on the finding label
Move a Label: left click and drag the finding label

Example of the findings section

Generally, the entire Findings Section represents a required field – it cannot be left blank. Either one or more findings must be entered, or one of the “Normal Findings” fields must be checked. The Pertinent Negatives area (“Were any of the following NOT SEEN on the exam?”) fields do not count toward completing the requirement.

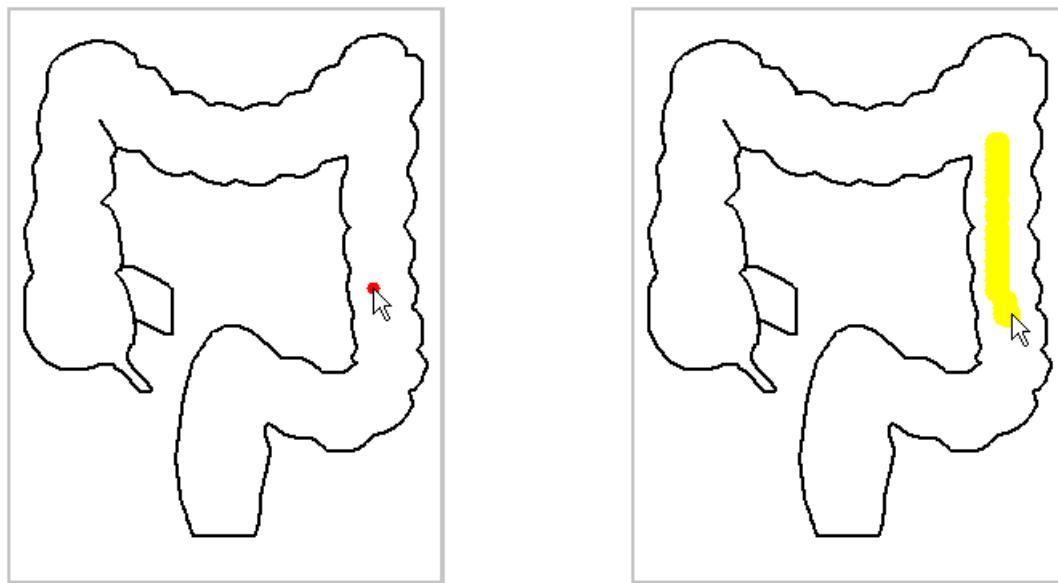
To create a Finding:

1. Click on a single spot to indicate a specific location.

Clinical Outcomes Research Initiative

www.cori.org

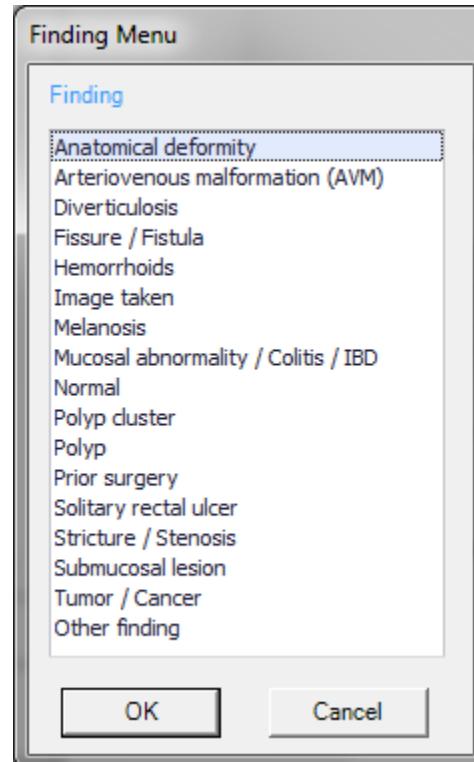
Page 52 of 100



2. To indicate a region rather than a specific location, click and drag within the diagram.

NOTE: Generally you cannot select locations outside the diagram outline. However, in the EUS procedure, locations outside the diagram outline can be selected.

3. When the mouse button is released the Findings Screen appears, listing the findings available for the procedure type.

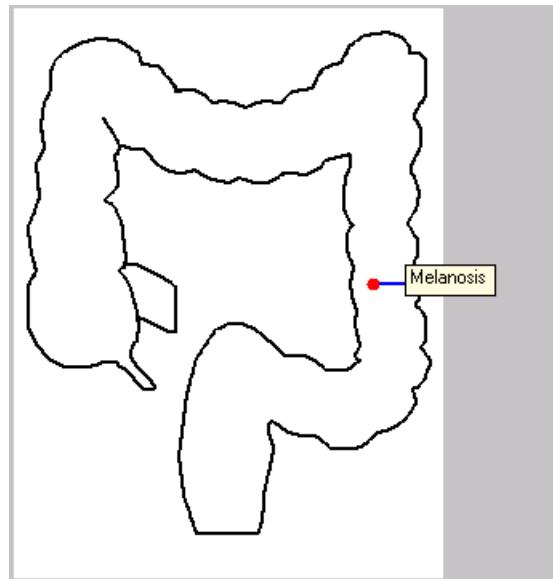


4. Select an entry from the Finding screen to display its Finding Detail screen, which contains fields for documenting the finding.

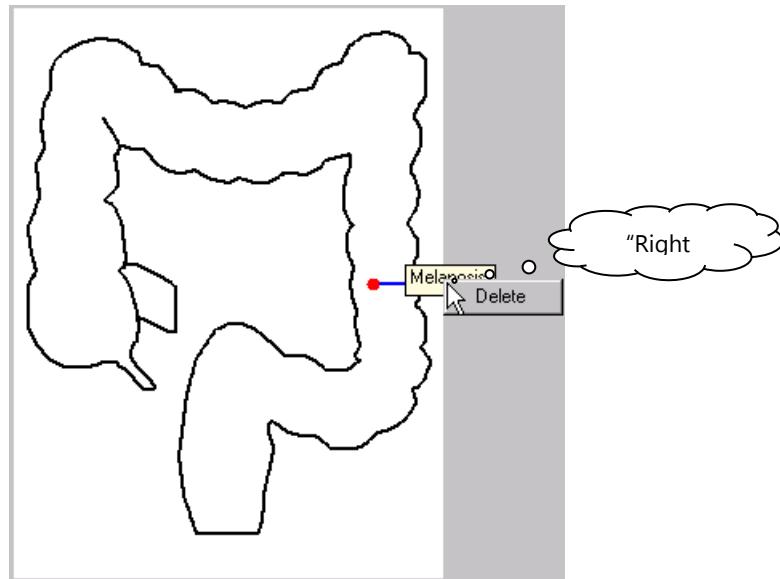
Melanosis

Starting location	Descending colon	<input type="checkbox"/> Image(s) taken
Ending location	Descending colon	
Diagnostics		
<input type="checkbox"/> Biopsy taken		
Total # of biopsies taken		
Sent to pathology <input type="radio"/> Yes <input type="radio"/> No		
Enter pathology ID		
<input type="text"/> <input type="button" value="Add"/>		
Current pathology IDs		
<input type="button" value="Save"/> <input type="button" value="Cancel"/>		

5. Click to close the Finding Detail screen and return to the Findings Section. The diagram displays a finding label attached to the selected location:

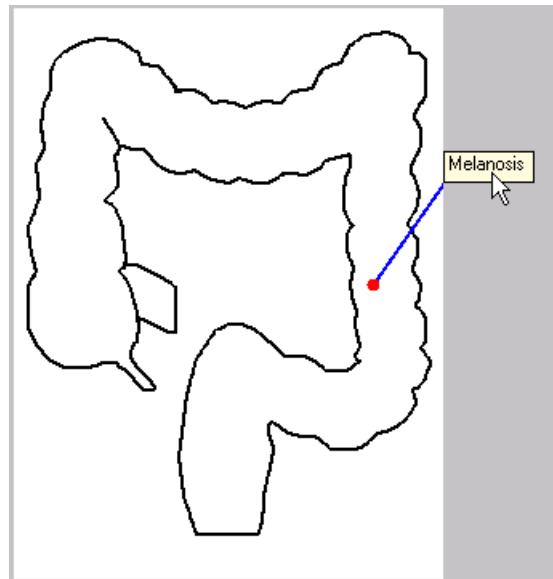


6. Click to discard the information in the Finding Detail screen and clear the location on the diagram.
 7. To reopen the Finding Detail screen for editing, double-click the finding label.
 8. To delete an existing finding, right-click the finding label and select *Delete*.



Deleting a finding removes all information in its Finding Detail screen, including "embedded" pathology information (see [Entering Pathology Information in a Finding Detail Screen](#)) and image associations (see [Adding Images to a Finding](#)). Imported images remain in the procedure record (see [Importing and Exporting in CORI v4](#)).

The finding label can be moved around within the diagram to the edge of the white area, to make room for additional finding labels. The blue line adjusts automatically, keeping the finding label connected to its location on the diagram. The location of the finding label in the diagram has no relation to its position on the printed procedure report.



[Entering Pathology Information in a Finding Detail Screen](#)

Certain Finding Detail screens include a Diagnostics area which contains fields for documenting pathology. Samples taken during a procedure can be listed in this area. The list appears in the Postprocedure Section once it is available (see [Postprocedure Section](#)), where pathology results can be entered.

Diagnostics

Biopsy taken

Total # of biopsies taken

Sent to pathology Yes No

Enter pathology ID

Current pathology IDs

This is not the same as importing a pathology report (see [Importing and Exporting in CORI v4](#)). This method “embeds” the information within the procedure report, whereas importing pathology report “attaches” the information to the report as a separate document.

To list a sample in a Finding Detail screen:

1. Select “Yes” in “Sent to pathology” option group to enable the “Enter pathology ID” text box.

Sent to pathology Yes No

Enter pathology ID

Current pathology IDs

2. Optionally, enter the sample’s identifier (which can be arbitrary, and is generally associated with an identifier on the sample’s container) in the text box and click . This creates a row in the “Current pathology IDs” list.

Sent to pathology Yes No

Enter pathology ID

Current pathology IDs

Sent to pathology Yes No

Enter pathology ID

Current pathology IDs Ja-1

3. Repeat step 2 for each sample taken.

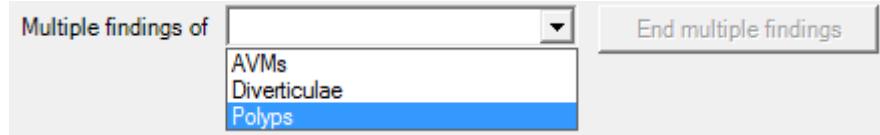
Multiple Findings

Certain findings can be entered in multiples at one time. This allows multiple occurrences of these findings to be selected at once in the diagram, and preliminary information about these findings can be entered

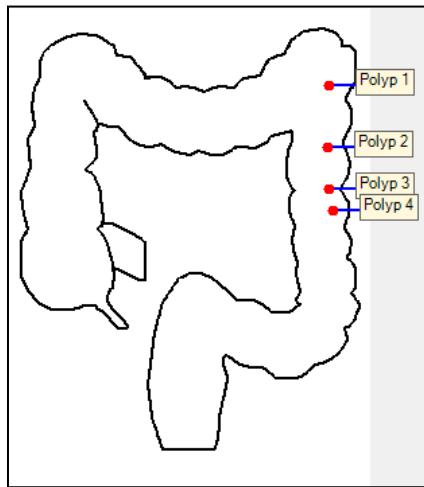
collectively. Once saved, the individual Finding Detail screens are used to enter data specific to each finding.

To create multiple findings:

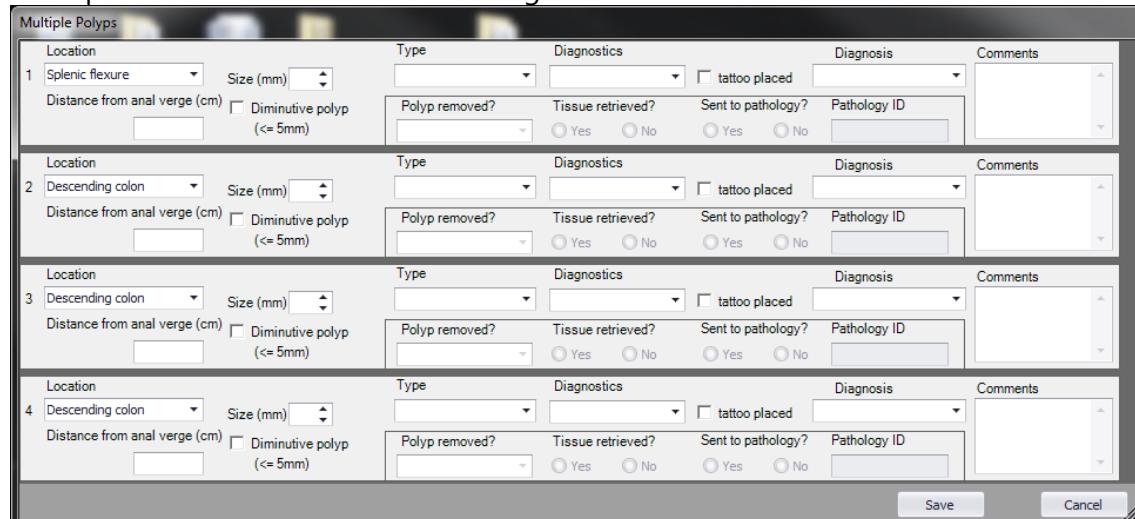
1. Select a finding from the "Multiple findings of" dropdown list.



2. Click or drag in the diagram multiple times to create findings.



3. When all of the findings have been created, click **End multiple findings**. The Multiple Findings screen appears, containing a set of fields for each finding. The number on the left edge of a set corresponds to the number in the finding label.

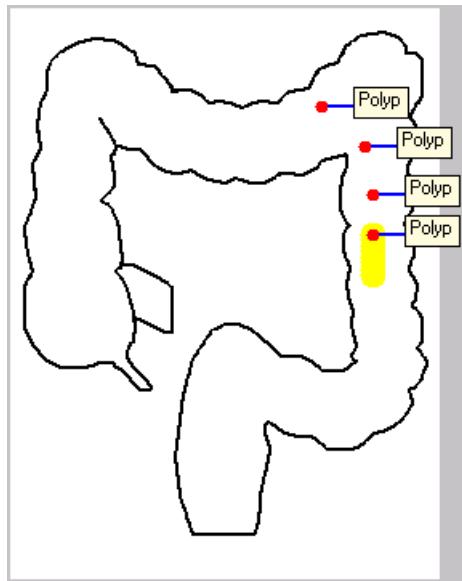


Location	Type	Diagnostics	Diagnosis	Comments		
1 Splenic flexure		<input type="checkbox"/> tattoo placed				
Distance from anal verge (cm)	<input type="checkbox"/> Diminutive polyp (<= 5mm)	<input type="checkbox"/> Polyp removed?	<input type="checkbox"/> Tissue retrieved?	<input type="checkbox"/> Sent to pathology?		
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	Pathology ID
2 Descending colon						
Distance from anal verge (cm)	<input type="checkbox"/> Diminutive polyp (<= 5mm)	<input type="checkbox"/> Polyp removed?	<input type="checkbox"/> Tissue retrieved?	<input type="checkbox"/> Sent to pathology?	<input type="checkbox"/> Pathology ID	
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	
3 Descending colon						
Distance from anal verge (cm)	<input type="checkbox"/> Diminutive polyp (<= 5mm)	<input type="checkbox"/> Polyp removed?	<input type="checkbox"/> Tissue retrieved?	<input type="checkbox"/> Sent to pathology?	<input type="checkbox"/> Pathology ID	
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	
4 Descending colon						
Distance from anal verge (cm)	<input type="checkbox"/> Diminutive polyp (<= 5mm)	<input type="checkbox"/> Polyp removed?	<input type="checkbox"/> Tissue retrieved?	<input type="checkbox"/> Sent to pathology?	<input type="checkbox"/> Pathology ID	
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	

4. Enter the desired data into the sets. Note the following:
 - Several fields initially copy the data entered in the first set to subsequent sets. This occurs the first time data is entered into the first set. All fields can be changed.
5. Enter the desired data into the sets. Note the following:
 - Several fields initially copy the data entered in the first set to subsequent sets. This occurs the first time data is entered into the first set. All fields can be changed.

- Not all of the fields in the individual Finding Detail screens are available in the sets. Additional data must be added using the individual Finding Detail screen.

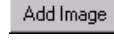
6. Click  to close the Multiple Findings screen and return to the Findings Section. The numbers in the finding labels disappear, and the labels now represent individual, unrelated findings.

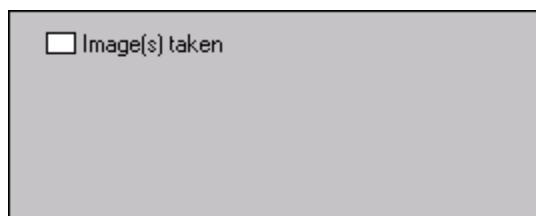


7. Click  to discard the information in the Multiple Findings screen and return to the Findings Section. The finding labels and their associated data are removed.

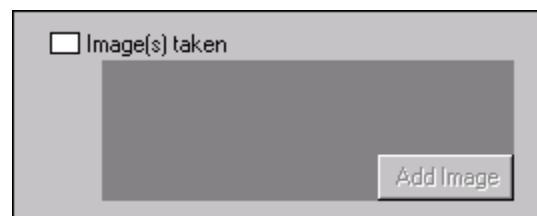
Adding Images to Findings

Adding images to procedure reports is a two step process. First, the images are imported into the procedure record (see [Importing and Exporting in CORI v4](#)), then individual images are associated with specific findings. Images can be imported into the procedure before or after creating findings.

If a finding can have images associated with it, its Finding Detail screen contains an "Image(s) Taken" area. Prior to importing images into the procedure, this area is blank. Once images have been imported into the procedure, the thumbnail gallery and the  button become visible:

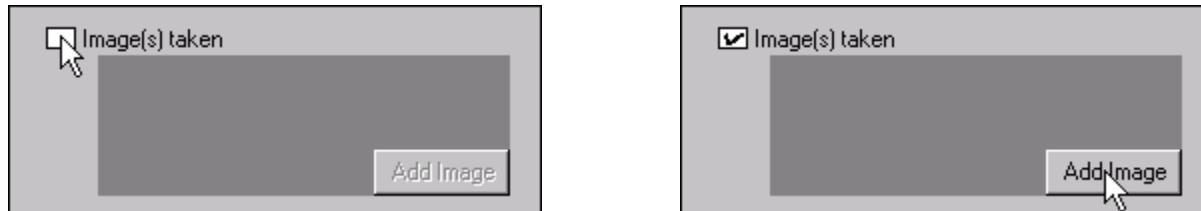


Before images are imported into the procedure

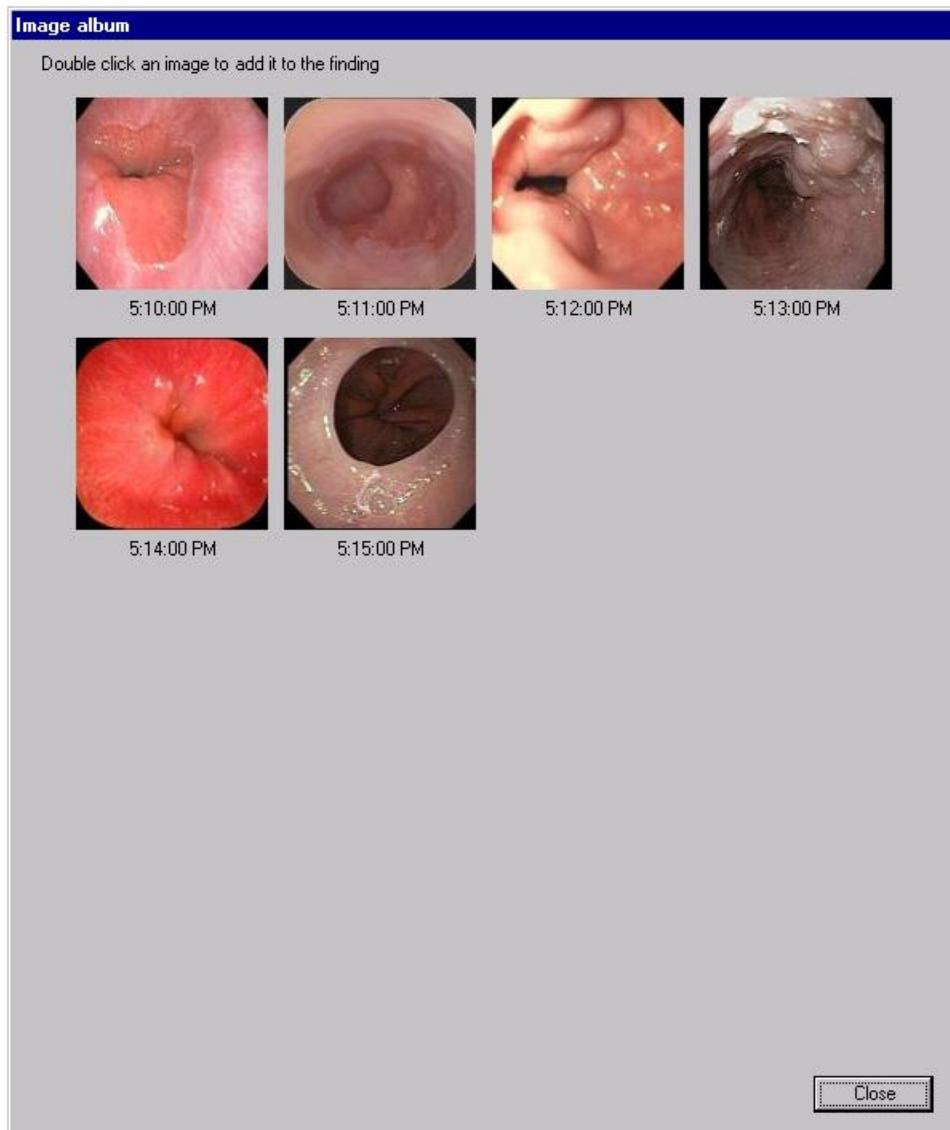


After images are imported into the procedure

- To associate an image with a finding, select the "Image(s) taken" checkbox and click on .



2. The Image album screen opens, displaying the images imported into the procedure, in the order in which they were taken.

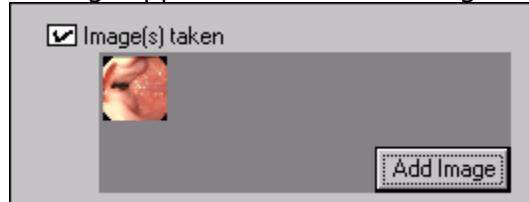


NOTE: The image captions do not reflect the time the images were taken.

3. Double-click on an image to associate it with the finding. Multiple images can be selected on this screen. Click on **Close** to return to the Finding Detail screen.

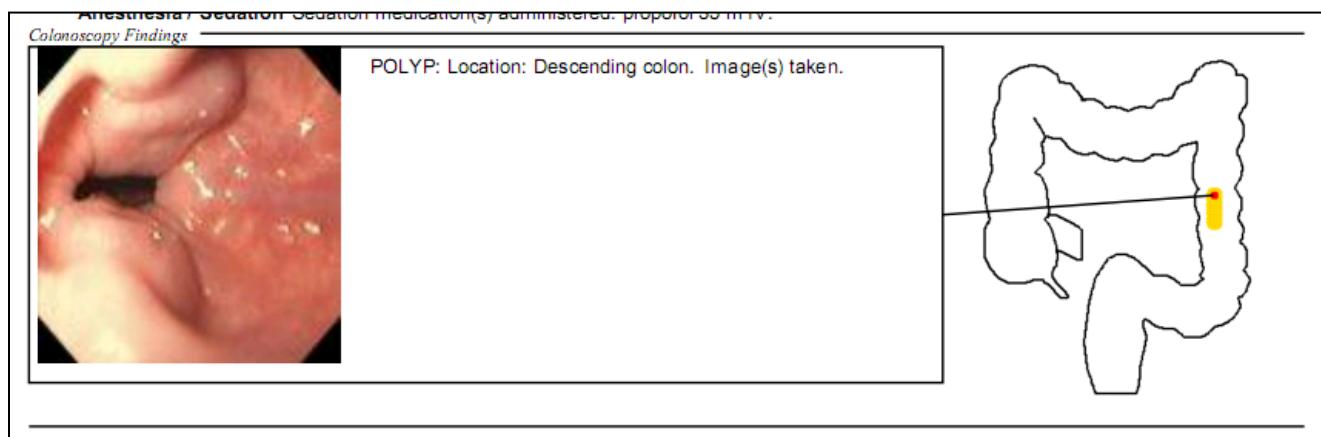


4. A thumbnail of the selected image appears in the thumbnail gallery.



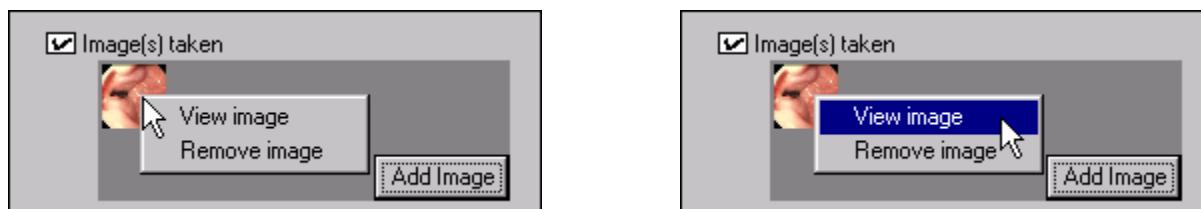
5. Save the Finding Detail screen to finish associating the image with the finding.

The image appears in the Findings Section of the printed procedure report, with other data entered into the Finding Detail screen, alongside the finding diagram.



Viewing or Removing an Image from the Thumbnail Gallery

Once an image has been added to the finding, click on its thumbnail to display a menu, allowing the image to be removed or viewed.



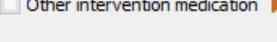
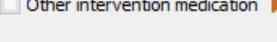
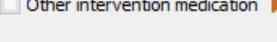
Selecting "View image" displays the image in its original size.



Selecting "Remove image" removes the image from the current finding, and returns it to the Image album.

Events Section

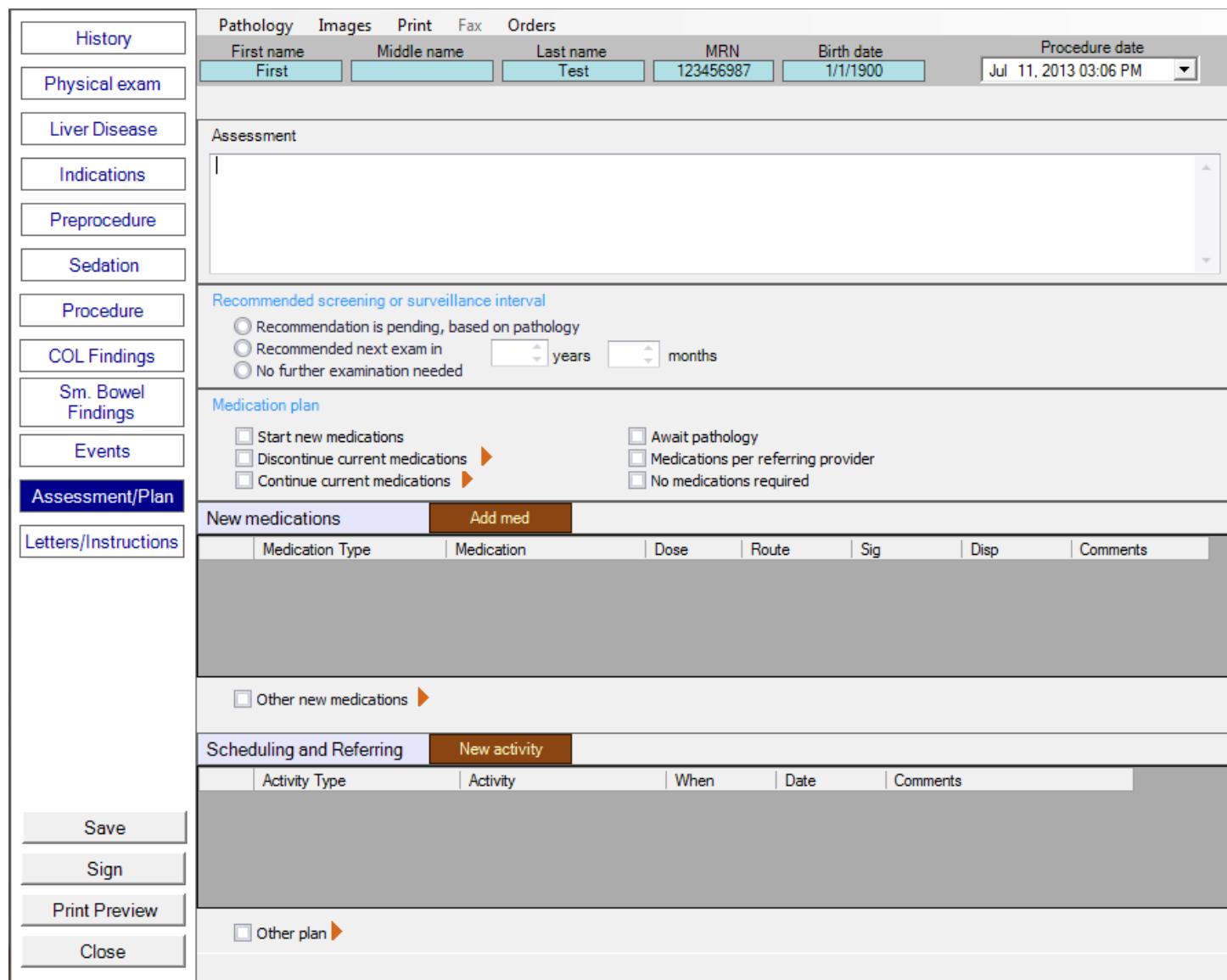
This section is for recording any unplanned events that occurred while performing the procedure. Answering yes or now for "Were there any unplanned events?" is required. However, including any more information in the form is only required if you select "Yes".

		Pathology	Images	Print	Fax	Orders	First name	Middle name	Last name	MRN	Birth date	Procedure date																																																		
							First		Test	123456987	1/1/1900	Jul 11, 2013 03:06 PM																																																		
		<p>Were there any unplanned events? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <table border="1"> <tr> <td> Cardiac events <ul style="list-style-type: none"> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Chest pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Tachycardia <input type="checkbox"/> Vasovagal reaction <input type="checkbox"/> Other cardiac event </td> <td> Pulmonary events <ul style="list-style-type: none"> <input type="checkbox"/> Elevated pCO2 <input type="checkbox"/> Hypoxia – prolonged (> 15 sec)  <input type="checkbox"/> O2 sat < 95% <input type="checkbox"/> O2 sat < 90% <input type="checkbox"/> Hypoxia – transient (<= 15 sec) <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Wheezing <input type="checkbox"/> Other pulmonary event  </td> <td> Gastrointestinal events <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bleeding  <input type="checkbox"/> >10 cc <input type="checkbox"/> <=10 cc <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Perforation <input type="checkbox"/> Other GI event  </td> <td> Other events <ul style="list-style-type: none"> <input type="checkbox"/> Death <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Drug reaction <input type="checkbox"/> Paradoxical reaction <input type="checkbox"/> Prolonged sedation <input type="checkbox"/> Rash/hives <input type="checkbox"/> Seizure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Other event  </td> </tr> <tr> <td colspan="2"> Interventions required? <input type="radio"/> Yes <input checked="" type="radio"/> No </td> <td colspan="3"> Intervention medication </td> <td colspan="3"> Add med </td> </tr> <tr> <td colspan="2"> If yes, specify the intervention(s) </td> <td colspan="3"> <table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Route</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="height: 100px;"></td> </tr> </tbody> </table> </td> <td colspan="3">  </td> </tr> <tr> <td colspan="2"> Were the interventions successful? <input type="radio"/> Yes <input checked="" type="radio"/> No </td> <td colspan="3"> Unplanned events/interventions comments <i>Please do not use this field if you can document the information using other fields on the screen</i> </td> <td colspan="3"> <div style="border: 1px solid #ccc; height: 100px; width: 100%;"></div> </td> </tr> <tr> <td colspan="2"> Select all that apply </td> <td colspan="3"></td> <td colspan="3"></td> </tr> <tr> <td colspan="2"> <ul style="list-style-type: none"> <input type="checkbox"/> Hemostasis achieved <input type="checkbox"/> O2 desaturation reversed <input type="checkbox"/> Spontaneous resolution of event <input type="checkbox"/> Vital signs stabilized </td> <td colspan="3"></td> <td colspan="3"></td> </tr> </table>											Cardiac events <ul style="list-style-type: none"> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Chest pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Tachycardia <input type="checkbox"/> Vasovagal reaction <input type="checkbox"/> Other cardiac event 	Pulmonary events <ul style="list-style-type: none"> <input type="checkbox"/> Elevated pCO2 <input type="checkbox"/> Hypoxia – prolonged (> 15 sec)  <input type="checkbox"/> O2 sat < 95% <input type="checkbox"/> O2 sat < 90% <input type="checkbox"/> Hypoxia – transient (<= 15 sec) <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Wheezing <input type="checkbox"/> Other pulmonary event  	Gastrointestinal events <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bleeding  <input type="checkbox"/> >10 cc <input type="checkbox"/> <=10 cc <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Perforation <input type="checkbox"/> Other GI event  	Other events <ul style="list-style-type: none"> <input type="checkbox"/> Death <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Drug reaction <input type="checkbox"/> Paradoxical reaction <input type="checkbox"/> Prolonged sedation <input type="checkbox"/> Rash/hives <input type="checkbox"/> Seizure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Other event  	Interventions required? <input type="radio"/> Yes <input checked="" type="radio"/> No		Intervention medication			Add med			If yes, specify the intervention(s)		<table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Route</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="height: 100px;"></td> </tr> </tbody> </table>			Medication	Dose	Route							Were the interventions successful? <input type="radio"/> Yes <input checked="" type="radio"/> No		Unplanned events/interventions comments <i>Please do not use this field if you can document the information using other fields on the screen</i>			<div style="border: 1px solid #ccc; height: 100px; width: 100%;"></div>			Select all that apply								<ul style="list-style-type: none"> <input type="checkbox"/> Hemostasis achieved <input type="checkbox"/> O2 desaturation reversed <input type="checkbox"/> Spontaneous resolution of event <input type="checkbox"/> Vital signs stabilized 							
Cardiac events <ul style="list-style-type: none"> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Chest pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Tachycardia <input type="checkbox"/> Vasovagal reaction <input type="checkbox"/> Other cardiac event 	Pulmonary events <ul style="list-style-type: none"> <input type="checkbox"/> Elevated pCO2 <input type="checkbox"/> Hypoxia – prolonged (> 15 sec)  <input type="checkbox"/> O2 sat < 95% <input type="checkbox"/> O2 sat < 90% <input type="checkbox"/> Hypoxia – transient (<= 15 sec) <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Wheezing <input type="checkbox"/> Other pulmonary event  	Gastrointestinal events <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bleeding  <input type="checkbox"/> >10 cc <input type="checkbox"/> <=10 cc <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Perforation <input type="checkbox"/> Other GI event  	Other events <ul style="list-style-type: none"> <input type="checkbox"/> Death <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Drug reaction <input type="checkbox"/> Paradoxical reaction <input type="checkbox"/> Prolonged sedation <input type="checkbox"/> Rash/hives <input type="checkbox"/> Seizure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Other event  																																																											
Interventions required? <input type="radio"/> Yes <input checked="" type="radio"/> No		Intervention medication			Add med																																																									
If yes, specify the intervention(s)		<table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Route</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="height: 100px;"></td> </tr> </tbody> </table>			Medication	Dose	Route																																																							
Medication	Dose	Route																																																												
Were the interventions successful? <input type="radio"/> Yes <input checked="" type="radio"/> No		Unplanned events/interventions comments <i>Please do not use this field if you can document the information using other fields on the screen</i>			<div style="border: 1px solid #ccc; height: 100px; width: 100%;"></div>																																																									
Select all that apply																																																														
<ul style="list-style-type: none"> <input type="checkbox"/> Hemostasis achieved <input type="checkbox"/> O2 desaturation reversed <input type="checkbox"/> Spontaneous resolution of event <input type="checkbox"/> Vital signs stabilized 																																																														

Example of the Unplanned Events Section

Assessment/Plan Section

The Assessment/Plans Section is where assessment text can be added to the report. The surveillance / screening interval can be set here, or deferred to post-procedure. The Medication plan area and the Scheduling and Referring tables are also in this section.



Assessment Text Area: The Assessment Section of the printed procedure report already includes Diagnosis information entered in findings (see [Findings Section](#)). This text area is for entering additional text.

Recommended screening or surveillance interval: The screening interval data can be entered here, or deferred until after the report is signed and entered in the Postprocedure Section (see [Postprocedure Section](#)). Queries can be run which retrieve a list of patients with specified recall dates ([See Queries Section](#)).

Scheduling and Referring Table: The Scheduling and Referring table is for documenting instructions that were given to the patient for future activity regarding the current procedure.

Scheduling and Referring		New activity					
	Activity Type	Activity	When	Date	Comments		
▶	Followup	Call office for biopsy res...	Around				
<input type="checkbox"/> Other plan ➤							
	Sun	Mon	Tue	Wed	Thu	Fri	Sat
	24	25	26	27	28	1	2
	3	4	5	6	7	8	9

Wednesday, March 20, 2013

March, 2013

Sun	Mon	Tue	Wed	Thu	Fri	Sat
24	25	26	27	28	1	2
3	4	5	6	7	8	9

Clear

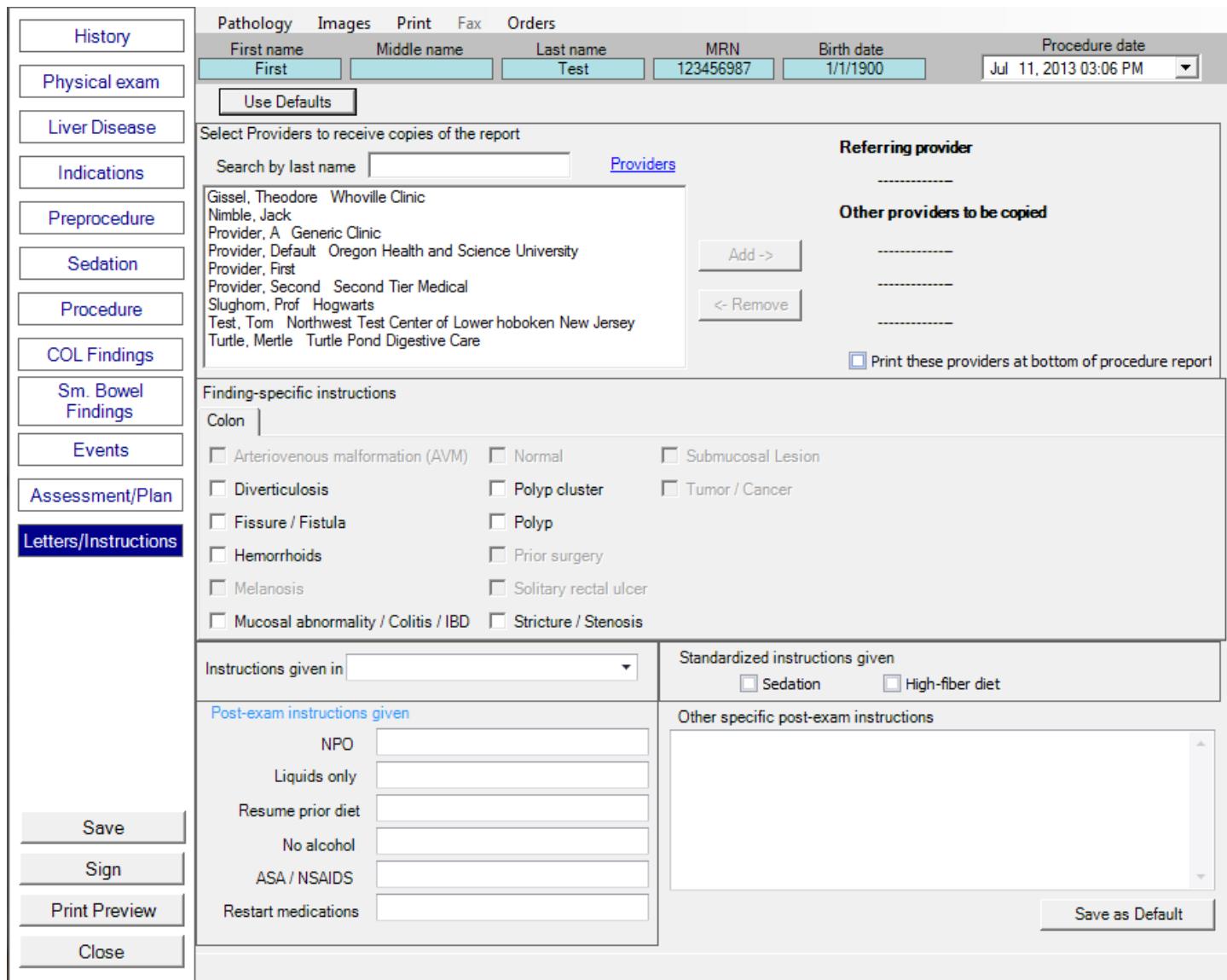
Zoom: 100% -

Size: 0.0KB

NOTE: The information entered here is not added to the CORI v4 Scheduler. It appears in the procedure report, and optionally the patient instruction handout.

Letters/Instructions Section

The Letters/Instructions Section is where referring providers are selected to receive referral letters, and where various instructions are selected for inclusion into the patient instruction handout. The templates for the referral letter, patient handouts and finding-specific instructions are managed by the Site Administrator. There are different templates and instructions for each procedure type.



Referral Letters: To select a provider to receive a referral letter:

1. Begin entering the last name of the provider into the "Search by last name" text box. The list of providers is displayed in the list box below, and narrows as more letters are typed into the field.
2. Click on the provider's name to select it.
3. Click on **Add >** to designate the Referring provider.
4. Select additional providers and click on **Add >** to designate them to receive copies of the referral letter. These providers will appear on the referral letter in a cc: line.

5. Click on any designated provider's name and click on  to remove them from the list of providers designated to receive a letter.
6. Optionally, select the "Print these providers at the bottom of procedure report" checkbox to include the names of the copied providers in the procedure report.
7. Click on  in the Navigation Bar to save changes to the referral letter. If the report has been signed, it must be signed again by clicking on  at the bottom left side of the screen.
8. Select "Referral letter" in the Print menu to preview the letter to the referring provider.
9. Referral letters are generally printed along with the printed report (see [Printing, Faxing and Previewing a Procedure](#)).

The [Providers](#) link displays the Providers screen, which allows a provider record to be created or edited, and selected to receive a referral letter (see [Providers Page](#)).

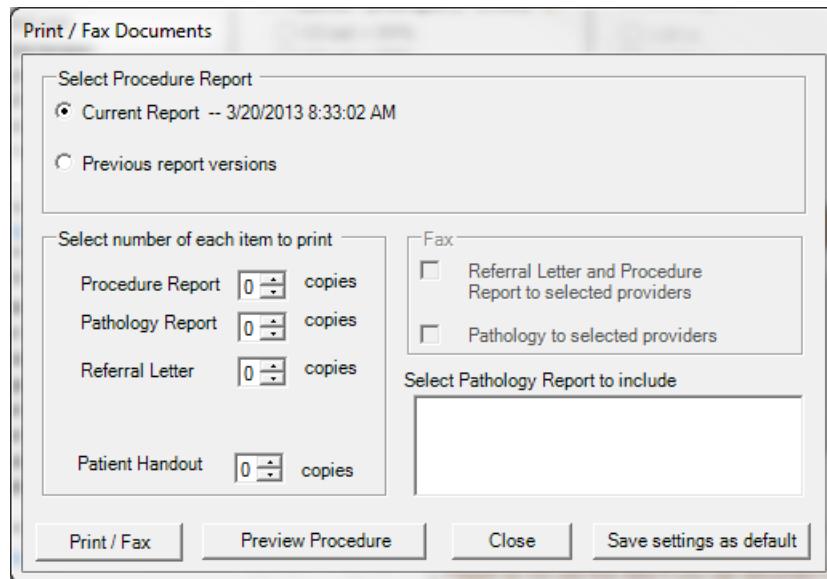
Multiple Referral Letters: CORI v4 can be configured to generate two different referral letters. One letter is addressed to the Referring provider selected in this section, and a second letter is common to the copied providers, but individually addressed to each of them.

The referral letter templates can also be configured such that the letter to the Referring provider will list the copied providers in the cc area, and the letters to the copied providers will cc the other providers in "round-robin" fashion. For example:

If the referring provider is Dr. A, and Drs. B and C are designated as copied providers:

- The letter addressed to Dr. A will indicate a cc to Drs. B and C.
- The letter addressed to Dr. B will indicate a cc to Drs. A and C.
- The letter addressed to Dr. C will indicate a cc to Drs. A and B.

When this option is enabled, the Print / Fax dialog functions differently as well:



The numeric field for the referral letters designates the number of copies of each letter to be generated, rather than the total number of copies. In other words, using the above example, selecting "1" in this field will produce 1 letter for Dr. A, one for Dr. B, and one for Dr. C. A "2" will produce two copies for each doctor, etc.

Patient Instruction Handouts: Patient instruction handouts are created from a combination of a customized template, customized instructions selected by the user, and specific instructions entered by the user. To create a patient instruction handout:

1. Add finding-specific instructions by clicking the checkbox next to the finding. A grayed out instruction means that there is no text available to include in the handout. The Site Administrator can add or change the text associated with a specific instruction.
2. The "Instructions given in" dropdown list allows the language for the handout to be selected. This defaults to English if it is not used. Handouts in other languages must be created by the Site Administrator – CORI v4 does not translate between languages.
3. Select the "Sedation" or "High-fiber diet" checkboxes to include customized instructions – which are common across all procedure types – in the report.
4. Enter time information in the "Post-exam instructions given" text boxes to include the instructions in the handout. The entered text is directly transferred to the handout:

Post-exam instructions given	
NPO	<input type="text"/>
Liquids only	<input type="text"/>
Resume prior diet	<input type="text"/>
No alcohol	<input type="text"/>
ASA / NSAIDS	<input type="text"/>
Restart medications	<input type="text"/>

Post-exam Instructions:

No food or liquids: 1 hour
 Liquids only: next 24 hours
 Resume prior diet: in 1 day

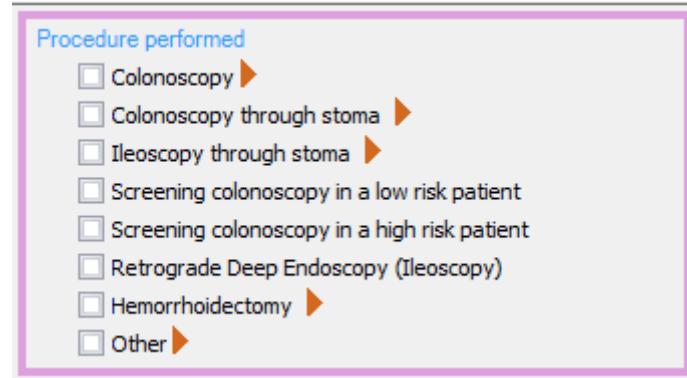
5. The "Other specific post-exam instructions" text area allows free-form text to be included in the handout.
6. Click on **Save** in the Navigation Bar to save changes to the handout. If the report has been signed it must be signed again by clicking on **Sign** at the bottom left side of the screen.
7. Select "Patient handout" in the Print menu to preview the patient instruction handout.
8. Patient handouts are generally printed along with the printed report (see [Printing, Faxing and Previewing a Procedure](#)).

Completing a Procedure Report

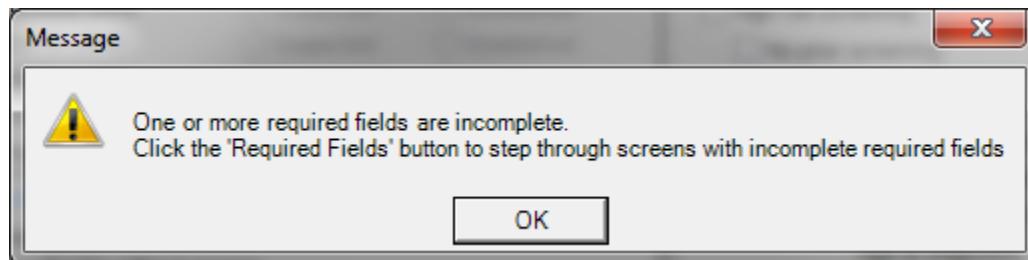
This chapter discusses aspects of CORI v4 required for completing, signing, printing and faxing a procedure report.

Required Fields

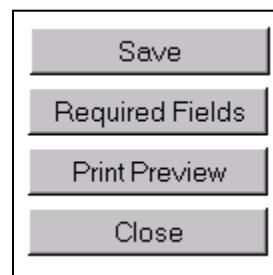
CORI v4 procedure reports have both required and optional fields. Required fields remain highlighted in purple until completed. Procedure reports cannot be electronically signed until all required fields are completed.



Attempting to sign a procedure report before completing all required fields produces a warning dialog:



In addition, the **Sign** button changes to **Required Fields**, and the first section with an incomplete required field is displayed.



Complete all required fields in the section, and click **Required Fields** to display the next section with incomplete required fields. Continue completing required fields and clicking **Required Fields** until the Signature Procedure screen appears.

Dependent Required Fields

Certain required fields depend on data entered in a non-required field. For example, since the list of entries for the required "Responsible Endoscopist" dropdown list in the Preprocedure Section is obtained from the

Procedure Personnel table, the table itself is effectively required, at least to the extent that there must be a row with an Endoscopist/Bronchoscopist staff role.

Procedure personnel		Add staff
Role	Name	
Endoscopist - Atten...	Corey Cori, MD	
► Endoscopist - Fellow	Ima Fellow Not MD	

Procedure performed by

Corey Cori, MD
 Ima Fellow Not MD

Procedure personnel		Add staff
Role	Name	
Endoscopist - Atten...	Corey Cori, MD	
► Endoscopist - Fellow	Ima Fellow Not MD	

Procedure performed by

Corey Cori, MD
 Ima Fellow Not MD

In most cases, dependent required fields will automatically complete when one item in the dependency (an Endoscopist/Bronchoscopist row in the Procedure personnel table) exists. Creating or selecting a second item in the dependency will clear the required field, requiring that a selection be manually entered.

Responsible Endoscopist / Bronchoscopist Field

Procedure personnel		Add staff
Role	Name	
Endoscopist - Atten...	Corey Cori, MD	
► Endoscopist - Fellow	Ima Fellow Not MD	

Procedure performed by

Corey Cori, MD

Responsible endoscopist

Corey Cori, MD

The Responsible Endoscopist/Bronchoscopist dropdown list in the Preprocedure Section indicates the person who has taken primary responsibility for performing the procedure. This information appears on the report, and is also used on the Patients and Procedures Pages as an extra criterion for searching the respective records.

[Signing a Procedure](#)

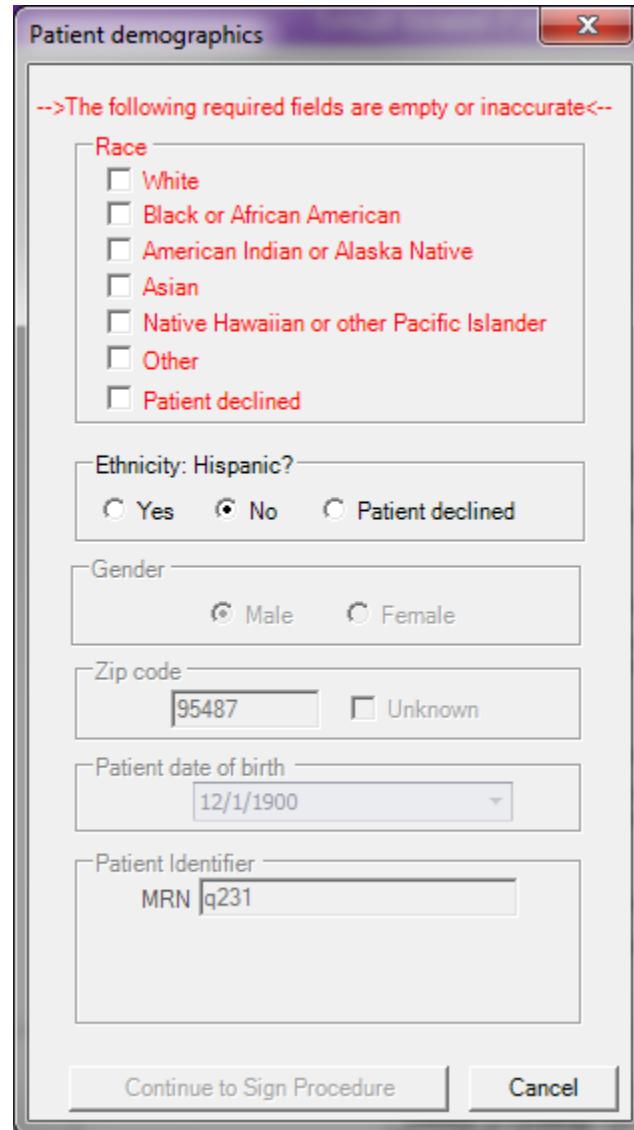
A CORI v4 procedure record is not complete until it has been electronically signed. An electronic signature indicates that the signer has taken responsibility for some or all of the procedure content. In this sense it functions like a traditional signature, and is legally valid as such.

Changes made to a signed report require it to be re-signed. See [Report Amendments and Addenda](#) for more information.

Only users with the "Sign procedure/Edit signed procedures" security permission can sign the main body of a procedure report. Permissions are assigned by the Site Administrator.

To Sign a Procedure Report:

1. Ensure that all required fields are complete.
2. Click on **Sign** in the Navigation bar.
3. If the patient record associated with the procedure does not have race, ethnicity or Zip code information, the Patient Demographics screen appears. Enter the required data and click on **Sign procedure**.



The dialog box is titled "Patient demographics". It contains the following fields:

- Race:** A list of checkboxes for race categories: White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Other, and Patient declined. The "White" checkbox is checked.
- Ethnicity: Hispanic?** A group of radio buttons: Yes, No, and Patient declined. The "No" radio button is selected.
- Gender:** A group of radio buttons: Male and Female. The "Male" radio button is selected.
- Zip code:** A text input field containing "95487" and a checkbox for "Unknown" which is unchecked.
- Patient date of birth:** A date input field showing "12/1/1900".
- Patient Identifier:** A text input field containing "MRN |q231".

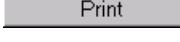
At the bottom are "Continue to Sign Procedure" and "Cancel" buttons.

4. The Sign Procedure screen appears.
5. Enter the user's electronic signature and click **Sign**.



The dialog box is titled "Sign Procedure". It contains the following text: "Corey Cori, MD, please enter your electronic signature". Below the text is a large empty rectangular box for the signature. At the bottom are "Cancel" and "Sign" buttons.

When a report is signed, the following events occur:

- A permanent PDF of the report is created and placed into the CORI v4 document archive.
-  is disabled.
-  changes to  (see [Printing, Faxing and Previewing a Procedure](#)).
- The Postprocedure Section is activated (see [Postprocedure Section](#)).
- If the CORI v4 is configured to export, the current version of the procedure report is exported (see [Importing and Exporting from CORI v4](#)).

Fellow Signature

For practice sites in an educational environment, such as a university hospital, CORI v4 allows a user with the "Endoscopist – Fellow" or "Bronchoscopist – Fellow" staff role (see [Staff Roles](#)) to sign a Procedure Report, indicating that the user has performed the procedure.

CORI v4 requires that an attending physician provide a counter-signature on the report signed by a fellow.

The attending physician's signature is not required in order for the report to be considered complete for the purposes of printing (see [Printing, Faxing and Previewing a Procedure](#)) and exporting the report (see [Importing and Exporting from CORI v4](#)). However, the printed report indicates that it has not been counter-signed by an Attending:



This report has not been signed by an attending physician

When an attending electronically signs the report, this warning is replaced by the attending physician's signature line.

If a fellow re-signs the report after the attending signs, the attending physician's signature line is removed and the warning is put back into the report. The report must then be signed again by an attending.

Report Amendments and Addenda

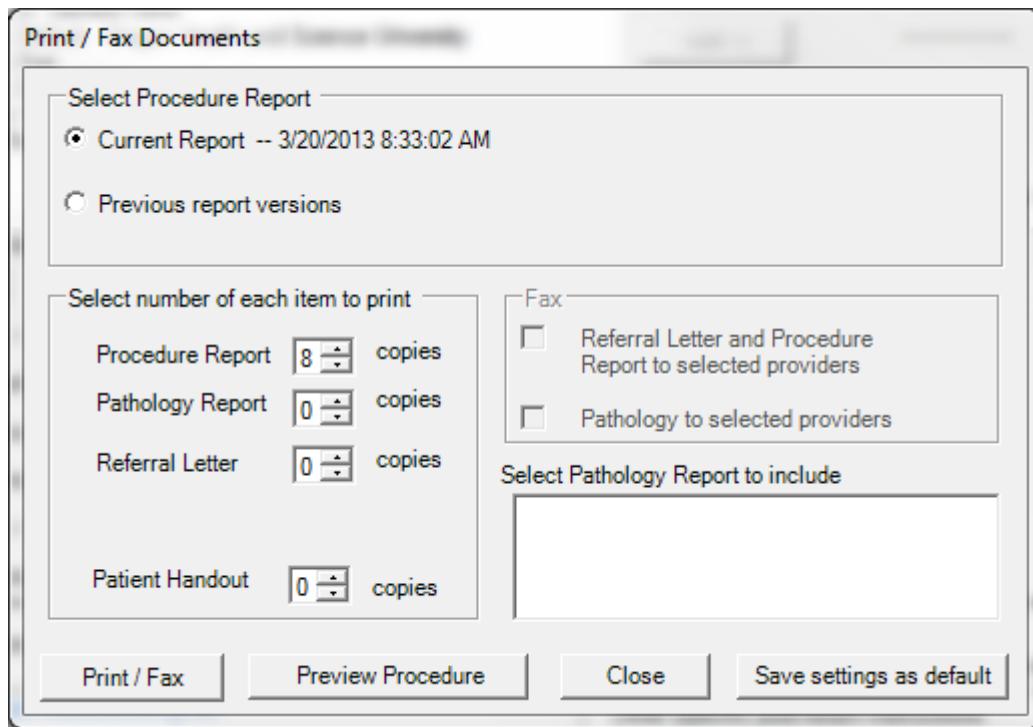
Procedure reports that are amended (i.e. changed after the report has been signed) must be signed again before they can be printed. Amended reports may display "Amended Report" in the header of the formatted procedure report. In addition, a new copy of the report PDF is created.

If the amended report is signed by a fellow, the attending physician's signature is removed from the report. The attending must counter-sign the report again (see [Fellow Signatures](#)).

Printing, Faxing and Previewing a Procedure

Once the procedure report has been signed, it can be printed as a complete report.

1. Click on **Print** in the procedure navigation bar to display the Print / Fax Documents Screen.



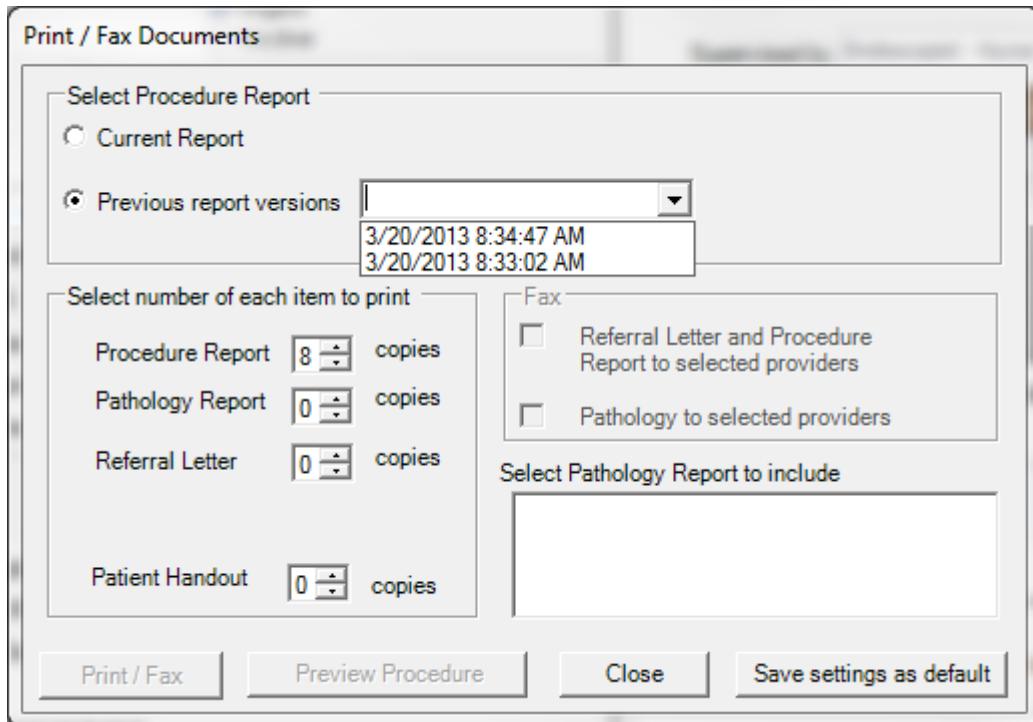
From this dialog, any of the documents created by CORI v4 can be printed, multiple times if desired, and – if faxing has been set up – simultaneously faxed to the providers selected in the Letters/Instructions Section (see [Letters/Instructions Section](#)). Imported pathology reports can also be faxed as well (see [Importing and Exporting in CORI v4](#)).

2. Select the number of copies of each document to print.
3. Select the checkboxes in the Fax area to fax the referral letter and procedure report, or an imported pathology report. Faxing must be configured for this to have any effect.
4. To preview the current procedure report, click on **Preview Procedure**.
5. Click on **Print / Fax** to print the selected number of copies of each of the CORI v4 documents to the Windows default printer, and to fax the selected documents as well.
6. Click on **Save settings as default** to retain the settings for printing and faxing for all users CORI v4 on the computer being used (printing defaults are saved per computer).
7. Click on **Close** to close the Print/Fax Documents Screen and return to the Procedure Window.

Previous Report Versions

Each time a procedure report is electronically signed a new copy of the report is created and permanently stored. Previous versions of the procedure report can be previewed or printed from the Print / Fax Documents Screen. To preview or print a previous report version:

1. Click on **Print** in the Procedure navigation bar to display the Print / Fax Documents screen.
2. Click the "Previous Report Versions" option in the "Select Procedure report" area.
3. Select a previous report version from the dropdown list that appears.
4. Click **Preview Procedure** to view the procedure report.
5. Click **Print / Fax** to print and/or fax the report.
6. Click on **Close** to close the Print/Fax Documents screen and return to the Procedure Window.



NOTE: Previous report versions will be faxed to the referring provider and copied providers selected in the current version of the procedure record.

Previous report versions are stored as PDF files and cannot be altered. These reports remain exactly as they were at the time they were signed regardless of any future changes to the procedure record or the CORI v4 software.

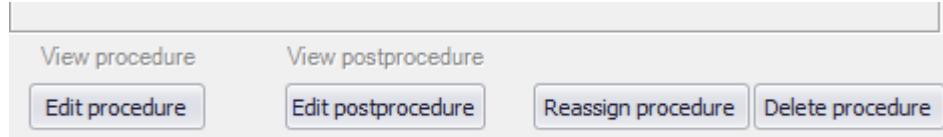
Postprocedure Module

The Postprocedure Module provides sections for entering post procedure information, documenting patient followup, and generating followup letters with results and recommendations for the patient and referring provider(s) that can be printed or faxed. All of the information entered in the window is printed on the post procedure report, which can be printed and/or faxed, along with any attached pathology reports. The postprocedure window can be accessed from two locations in CORI v4.

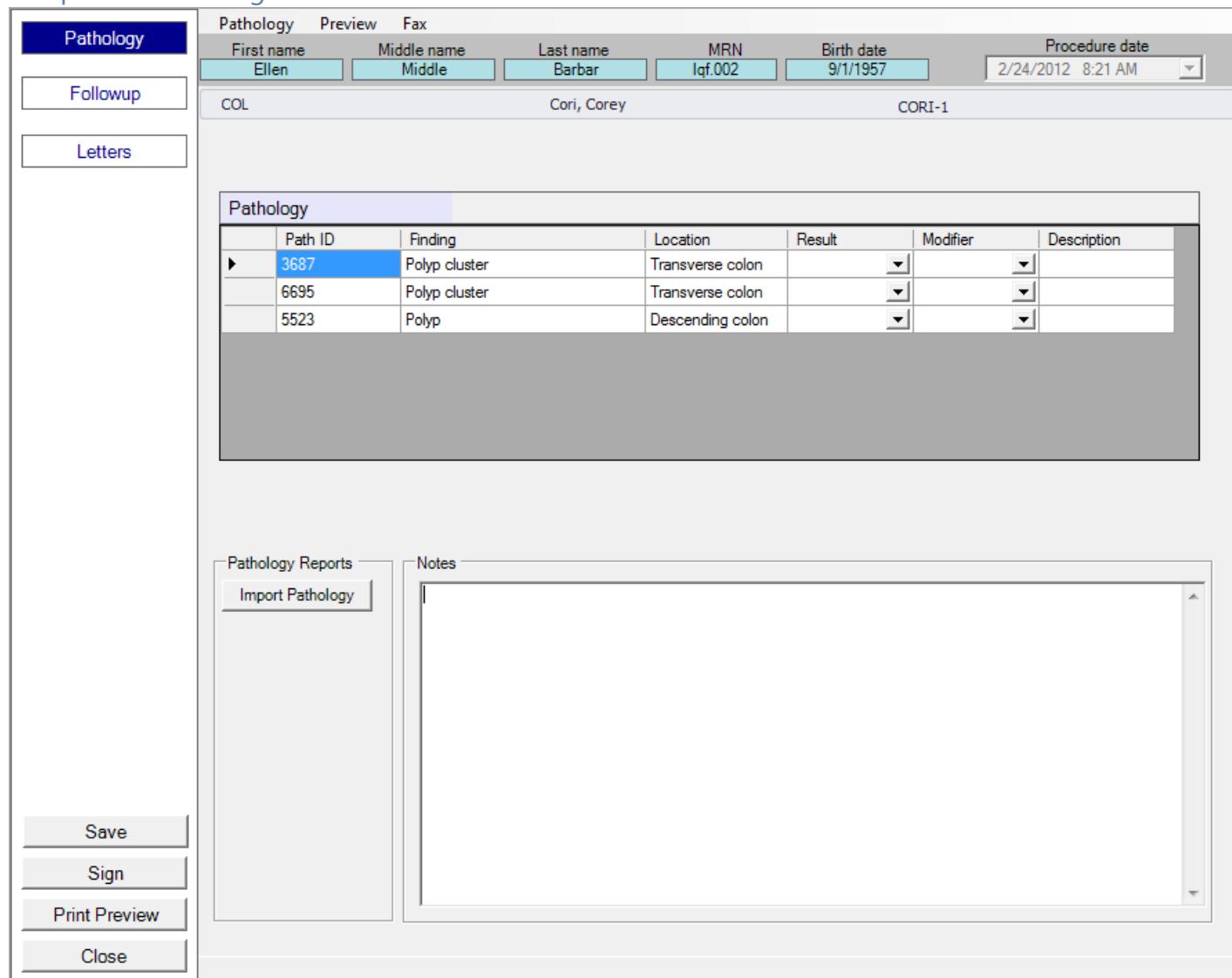
- Either here in the Patients tab next to the list of procedures



- Or here, in the Procedure tab



Postprocedure Navigation Bar



Pathology						
	Path ID	Finding	Location	Result	Modifier	Description
▶	3687	Polyp cluster	Transverse colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	
	6695	Polyp cluster	Transverse colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	
	5523	Polyp	Descending colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	

Click the buttons along the left side of the Postprocedure window to access the different sections.

Farther down the left side of the window are buttons used to manage the post procedure record.

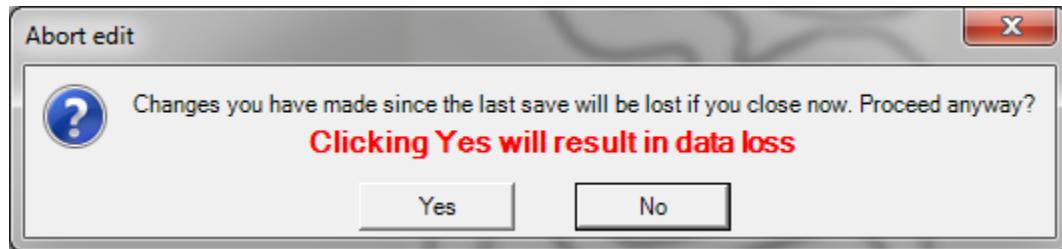
Click on  to save the postprocedure record as a work-in-progress. Postprocedure records may be saved at any time, until they are electronically signed. Once the report has been signed the *Save* button becomes disabled.

Click on  to electronically sign the post procedure record.

Click on  to display a preview of the unsigned post procedure report. Although the report can be printed from the Preview window, it contains a "Preliminary Report" watermark and is not suitable as a legal record.

Once the report has been electronically signed this button changes to  Print, providing more options (see [Printing Postprocedure Documents](#)).

Click on  Close to exit the Postprocedure window and return to the Main window. If changes have been made to the report since it was last saved or signed, a warning dialog will appear asking for confirmation to close the window.



Pathology Section

The Postprocedure module has a section dedicated to entering and editing pathology information for procedures that have been entered into CORI v4. By default, it is the first screen you will see in the Postprocedure module.

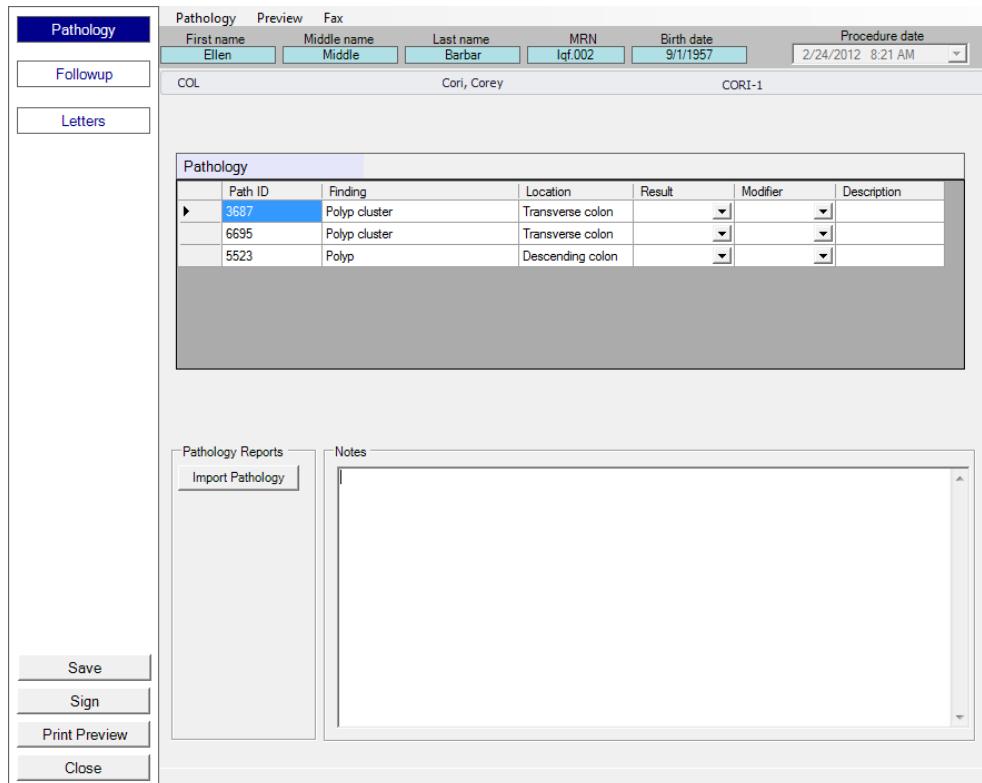
Pathology results can be included in or attached to Postprocedure reports generated in CORI v4. Since CORI v4 can interface with a variety of EHR and file formats; we have included several tools that you can use to import a pathology report into the CORI v4 application.

You can enter pathology information directly into the Pathology Grid in the Postprocedure window, as long as you have entered pathology ID's in the Findings screen of the Procedure report. They will be displayed in the Pathology section of the postprocedure window. This information will be inserted into the Postprocedure report.

The Pathology section of the Post Procedure window also has a notes field. The notes field offers you more flexibility in entering a pathology report. Here you can manually type in a pathology report, or copy and paste a report from a text document on your computer. This information will be inserted into the Postprocedure report.

CORI v4 also allows you to attach a pathology report that has been saved as a document. You can attach a report by locating the file on either your hard drive, removable storage drive, or a network storage device. Examples of files that can be attached are .pdf, .doc, .docx, or an image file, like .jpg. This information will not be inserted into the Postprocedure report, but will be available as an attached pdf.

Lastly, CORI v4 allows you to type or paste in text to the Report Note field in the import pathology page. This will attach pathology information for any report you add to the Post Procedure Report.

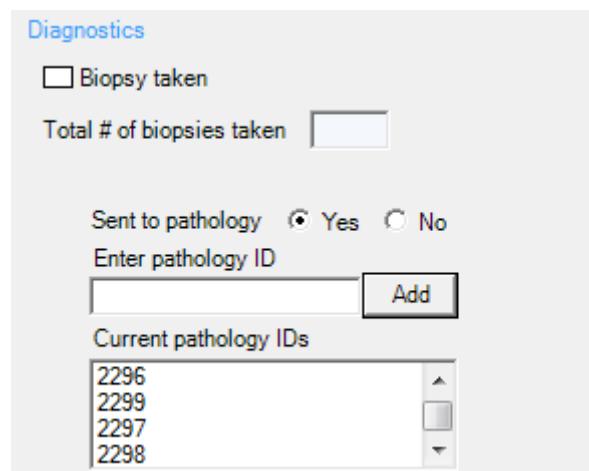


Path ID	Finding	Location	Result	Modifier	Description
3687	Polyp cluster	Transverse colon	☒	☒	
6695	Polyp cluster	Transverse colon	☒	☒	
5523	Polyp	Descending colon	☒	☒	

Pathology samples documented in the Findings Section appear as rows in the Pathology table in this section, where pathology results information can be entered. See [Entering Pathology Information in a Finding Detail Screen](#) for information on associating pathology samples with findings.

Entering Pathology Results using the Pathology grid:

CORI 4 allows you to manually enter pathology results for findings entered in the [Findings](#) section of the [Procedure](#) window. Any finding you enter in the Procedure section that has "Yes" selected next to "Sent to Pathology" will appear in the Pathology section at the center of the screen. This information will be embedded in the postprocedure report. Entering pathology results information in this grid is the only way to be able to run queries on quality measures such as detection and/or removal rate of adenomatous polyps, and other pathology results (See [Queries Page](#)).



Example from the Findings section of the Procedure section

1. In the picture above, you can see the Pathology ID, the finding, its location, and enter the results from the pathology report. Results and Modifiers are added from a drop down menu.

Pathology						
	Path ID	Finding	Location	Result	Modifier	Description
▶	263	Mucosal abnormality / Colitis	Transverse colon	▼	▼	
	3000	Polyp	Sigmoid colon	▼	▼	
	2296	Polyp	Descending colon	▼	▼	
	2299	Polyp	Sigmoid colon	▼	▼	
	2297	Polyp	Descending colon	▼	▼	
	2298	Polyp	Sigmoid colon	▼	▼	

An Example of Pathology taken from the Findings section. This is displayed in the Post Procedure window under the Pathology tab.

2. Below you can see a result being selected from the drop down menu.

Pathology						
Path ID	Finding	Location	Result	Modifier	Description	
263	Mucosal abnormality / Colitis	Transverse colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
3000	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
2296	Polyp	Descending colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
2299	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
2297	Polyp	Descending colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
2298	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		

Pathology Reports Notes

Import Pathology

Adenocarcinoma
Adenoma
Atypia
Barretts esophagus
Candida
Carcinoma
Celiac sprue
CMV
Colitis
Eosinophils
Granuloma
H. Pylori
Hyperplasia
Inflammation
Lymphoma
Normal
Polyp
Ulceration

Entering a Pathology result from the Drop down menu

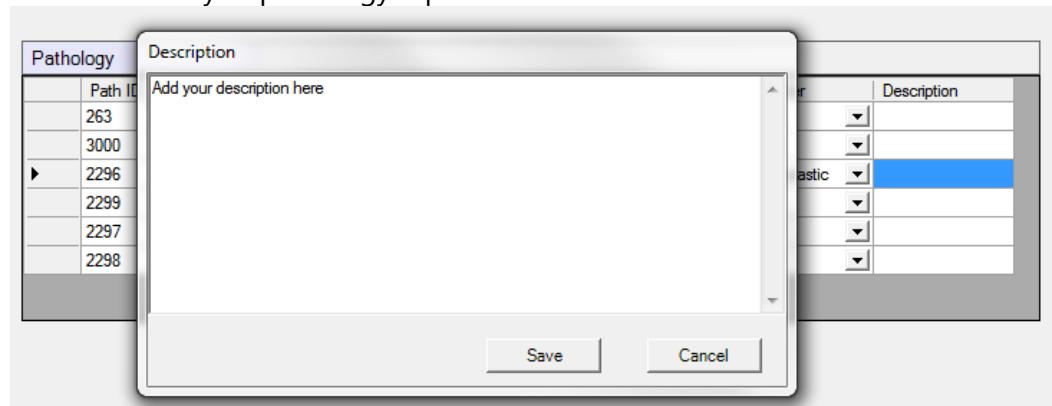
3. Below, you see that the pathology report is getting a modifier added from a drop down menu. This will allow you to give more specific information on the findings.

Pathology						
Path ID	Finding	Location	Result	Modifier	Description	
263	Mucosal abnormality / Colitis	Transverse colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
3000	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>		
2296	Polyp	Descending colon	Polyp	<input type="button" value="▼"/>	<input type="button" value="▼"/>	
2299	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	fundic gland	
2297	Polyp	Descending colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	hyperplastic	
2298	Polyp	Sigmoid colon	<input type="button" value="▼"/>	<input type="button" value="▼"/>	inflammatory	

fundic gland
hyperplastic
inflammatory
leiomyoma
lymphoid aggregate
retention

Adding a modifier to the pathology result from the Modifier drop down menu

4. Once you have made the selections you want, you can then type in the description. Selecting the box under Description opens up a new window. Here you can type in any relevant notes or additional information needed for your pathology report.



Adding a description to the pathology result

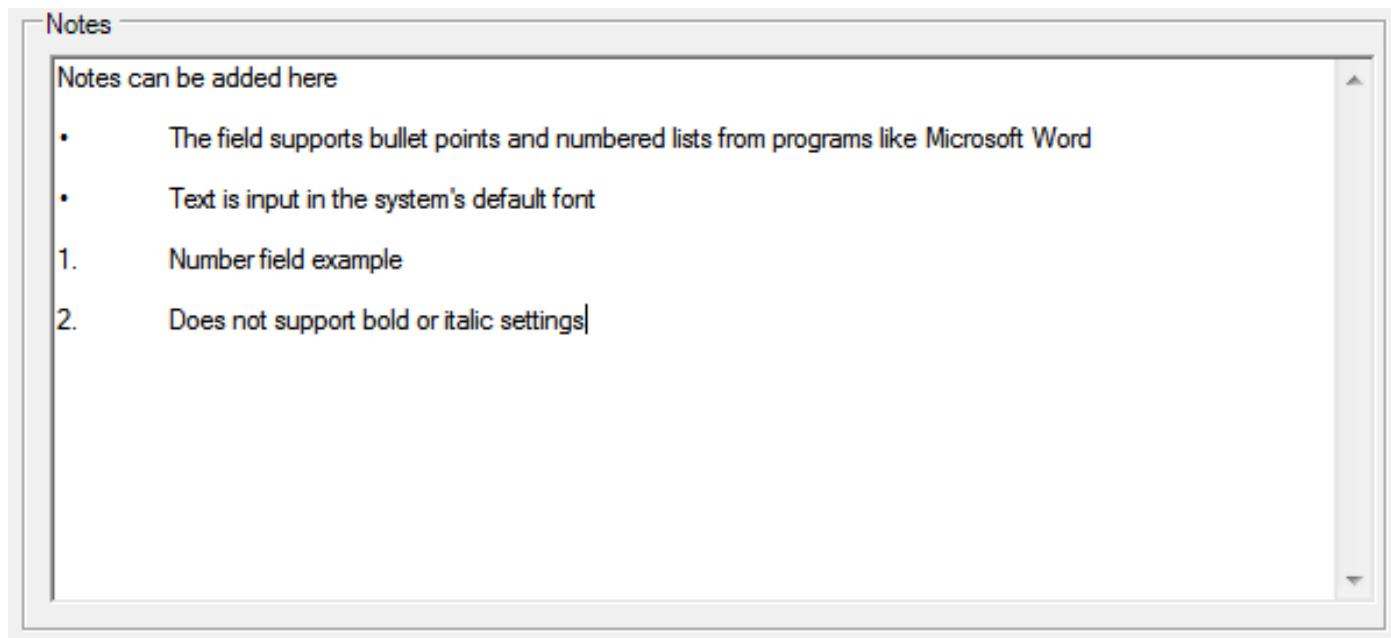
5. Once completed, the grid will look like this. You can edit any of the information by clicking on the box you would like to change.

Pathology						
Path ID	Finding	Location	Result	Modifier	Description	
263	Mucosal abnormality / Colitis	Transverse colon	Adenocarc...	invasive	notes here	
3000	Polyp	Sigmoid colon	Polyp	inflammatory	notes here	
2296	Polyp	Descending colon	Polyp	hyperplastic	Add your descri...	
2299	Polyp	Sigmoid colon	Polyp	leiomyoma	notes here	
2297	Polyp	Descending colon	Polyp	retention	notes here	
▶ 2298	Polyp	Sigmoid colon	Polyp	retention	notes here	

A completed pathology report from Findings

Entering Pathology Results in the Notes Field

CORI v4 also give you the option of typing or pasting the pathology report right into the postprocedure window. Any information you would like to have added to the Postprocedure Pathology report in may be entered here. You can also add pathology reports from other software suites by copying and pasting the results into this screen. Below you can see what settings the Notes field supports



The Notes section of the Post Procedure Pathology window

You edit the window by typing directly into it. Clicking on the text box does not open a new window; any text added is done directly into the field.

Importing Pathology Reports

Pathology reports can be imported and attached to a procedure or postprocedure report in CORI v4 in several ways: using an interface to an electronic pathology management system or by selecting files on an attached resource such as a network drive or a USB flash drive – PDF, text, and graphic (BMP, GIF, JPG or TIF) file formats are supported. You can also copy and paste a pathology report and attach it to the procedure or postprocedure report as a pdf.

Imported pathology information is not “embedded” in the Post Procedure report. Whether brought into CORI v4 as a data file, via electronic interface, or typed / pasted, it is stored separately and internally associated with the procedure report.

To import pathology information click on [Import Pathology](#) in the Postprocedure Section.

The Pathology Import screen is displayed, with search criteria from the current procedure entered and a search already performed.

View / Edit Order Details

Search

Last Name	ALEXANDER	First Name		Start date	Mar 13, 2013
DOB	4/30/1952	Clear DOB		End date	Mar 20, 2013
MRN			81750211	<input type="checkbox"/> Show completed	

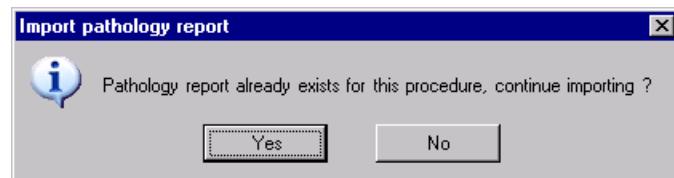
Detailed information for selected order

Last name	First name	Procedure
DOB	MRN	Account #
No results		Order #

Last name	First name	DOB	MRN	Type	Proc Description	Order Date

To enter your own order number, type the number into the "Order #" field above then click Save

NOTE: If a pathology report has already been imported into the current procedure report, a confirmation dialog is displayed. Click on to import another pathology report or on to cancel.



To import a pathology report via interface:

1. Results are displayed in the window below the patient information.

NOTE: If there are no search results, or too many results, change search criteria and search again, or search by date range.

2. Click the desired patient row.
3. Report text, if available, is displayed to the right of the search results.
4. Click on **Preview file** to display a preview of the pathology report.
5. Click on **Import** to import the pathology report.
6. A confirmation dialog is displayed. Click on **OK** to return to the procedure report.

Importing a pathology report from a folder on your hard drive, thumb drive, or network drive (where no interface exists):

1. Click on **Browse ...**. A standard File Open dialog appears.
2. By default the dialog will display PDF files. Select the "Files of type:" dropdown list and select other formats, such as text (.txt) or images (.bmp, .jpeg, .jpg, .gif, .tif, .tiff).
3. Navigate to the location of the pathology report file, select it and click on **Open**. The pathology report file is imported and associated with the current procedure report.

Entering or Pasting Pathology Text:

NOTE: Pasting text into the text area requires that it has been copied to the Windows clipboard.

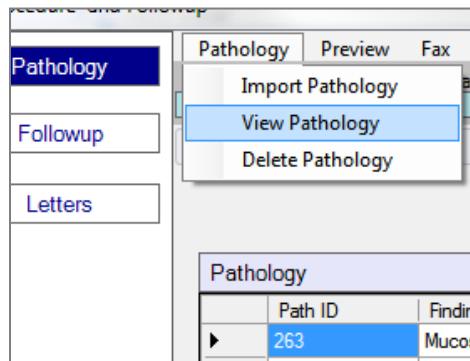
1. Click on **Create Report Note**. The Report Note text area to the right of the search results box changes to white.
2. Type the desired report notes, or press CTRL+V to paste copied report notes into the text area.
3. Click on **Import** to store the entered pathology note. The note is now saved separately from the procedure report and internally associated with it.

The indications that one or more pathology reports have been imported into a procedure are:

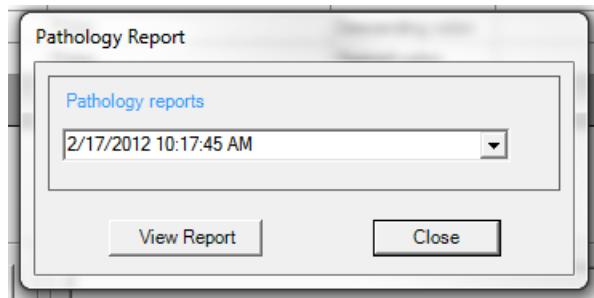
- The **View Pathology** button becomes available in the Post Procedure Section.
- The "View pathology report" menu entry becomes available.
- In the Procedures Page, the "Pathology reports available" checkbox is checked.

[To view an imported pathology report:](#)

1. Select "View Pathology Report" from the Pathology menu



2. The Pathology Report dialog appears, displaying a menu listing all available pathology report for the procedure.



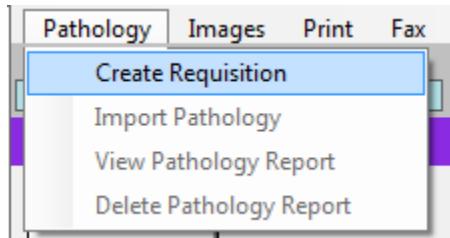
3. Select the desired report from the "Pathology reports" dropdown list.
4. Click on **View Report** to display the pathology report in a separate screen. The screen may be different depending on how the report was imported – a window with a large text field displays notes that were typed or pasted in; a PDF viewer displays imported PDF files; and a picture viewer displays imported images.



5. Close the preview screen and click on **Close** to return to the Post Procedure Section.

Creating a Pathology Requisition

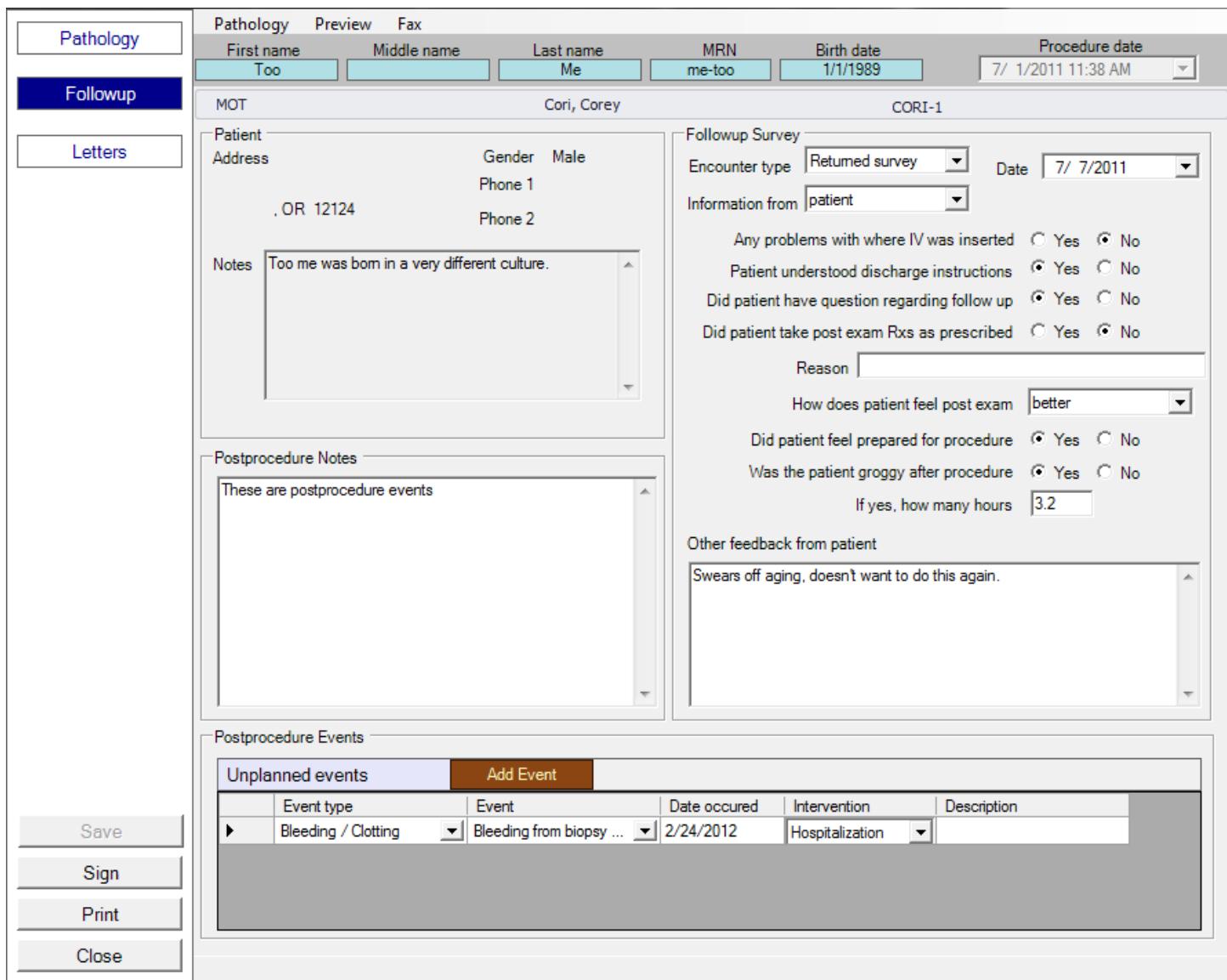
CORI v4 has the ability to interface with Pathconnect. This can be done from the Pathology menu in the Findings section of the procedure report.



This will open your web browser and CORI v4 can create the requisition. The requisition is then completed by the user and submitted. Results from this type of interface are imported into CORI v4 by an HL7-based interface.

Followup Section

This is where follow up information is recorded, and unplanned post procedure events are documented.



Unplanned events		Add Event		
	Event type	Event	Date occurred	Intervention
▶	Bleeding / Clotting	Bleeding from biopsy ...	2/24/2012	Hospitalization

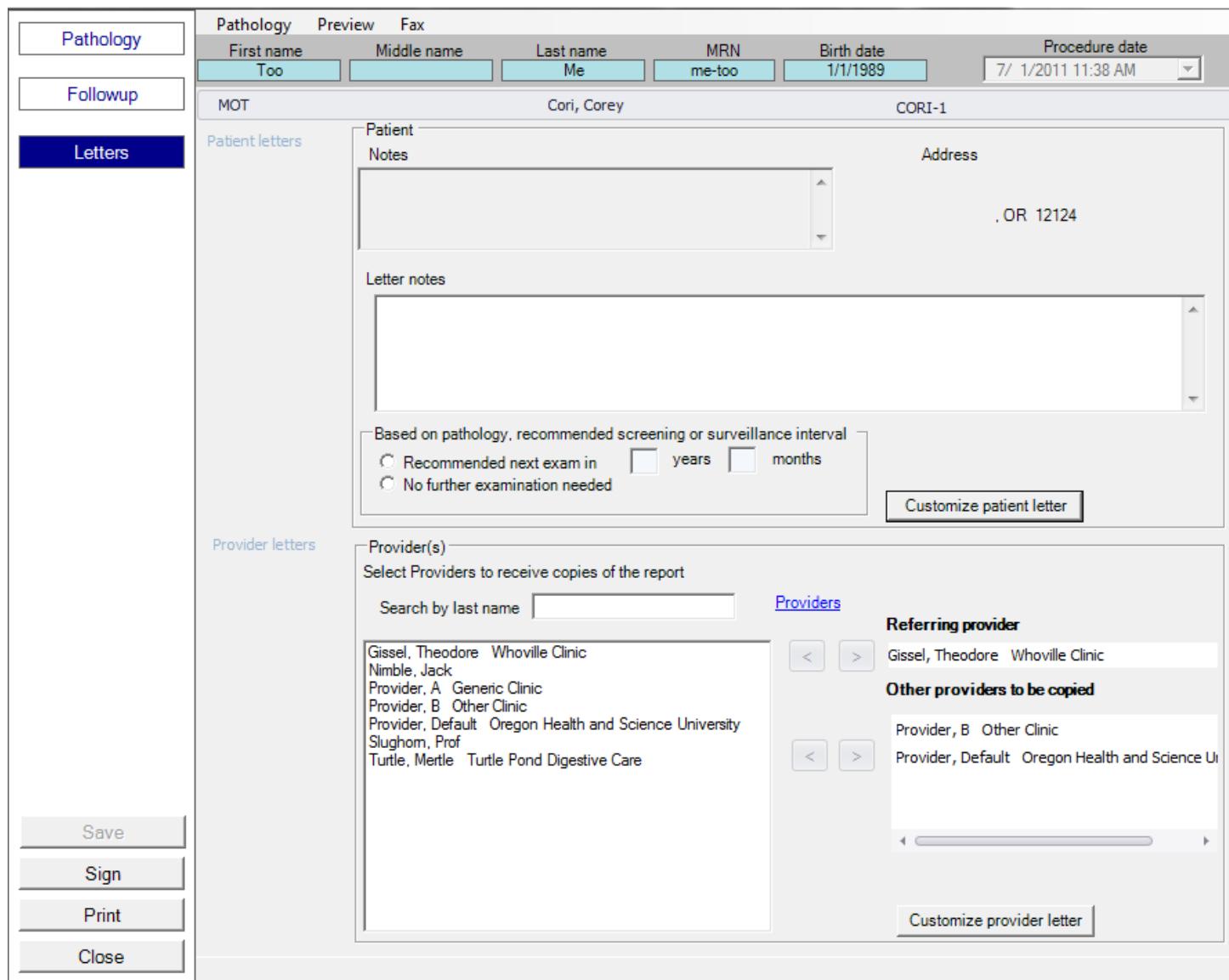
The Followup area is where the results of a follow up survey can be documented. Once a selection is made in the "Encounter type" drop down menu, the remaining fields in this section become enabled and can be used to record more details. This information appears in the postprocedure report.

The Postprocedure Notes text area may be used to record free-form postprocedure information.

Unplanned events are documented using the Unplanned Events table.

Letters Section

CORI v4 has the ability to generate follow up letters to the patient, the referring provider, and other providers designated to receive a copy of the postprocedure report. Just as with Procedure letters, templates can be created for Postprocedure patient and referring provider letters you're your Administrator). The letters can also be customized by the user just before printing or faxing. In addition, setting the surveillance interval based on pathology information is done in this section. A query can be run to retrieve all patients with a specified recall date ([See Queries Page](#)).



Customizing Followup Letters

The letters generated in the Post Procedure window are created from templates managed by the Site Administrator. If the "Recommended next exam" and "Referring provider" information are to be included in the letters, the associated fields in this section must be completed. In addition, the "Other providers" field must be completed in order to generate a letter specifically to someone other than the referring provider (CORI v4 must also be configured to provide this feature).

If no changes to the letters are needed, they can be printed from the standard print dialog (see [Printing Post Procedure Documents](#)). However, if customization of a letter is required, the text can be modified as needed before printing. To customize the patient letter:

1. Click on **Customize Patient Letter** to display the text of the letter in a panel overlaying the patient letter area.
2. Make the desired changes.
3. Save or sign the post procedure record.

[Pathology](#)
[Followup](#)
Letters

[Save](#)
[Sign](#)
[Print](#)
[Close](#)

Pathology
Preview
Fax

First name	Middle name	Last name	MRN
Too		Me	me-too
Birth date		Procedure date	
1/1/1989		7/ 1/2011 11:38 AM	

MOT
Cori, Corey
CORI-1

Patient

2/24/2012

, OR 12124

Dear Too Me,

We have received the results of the motility study you had on 7/1/2011.

You were referred to us for your examination by Theodore Gissel, MD.

Pathology results:

Additional information:

Based on the above results, your recommended next exam is:

Provider letters

Provider(s)

Select Providers to receive copies of the report

Search by last name

Providers
Referring provider

Gissel, Theodore Whoville Clinic	Gissel, Theodore Whoville Clinic
Nimble, Jack	
Provider, A Generic Clinic	
Provider, B Other Clinic	
Provider, Default Oregon Health and Science University	
Slughom, Prof	
Turtle, Mertle Turtle Pond Digestive Care	

<
>

Other providers to be copied
<
>

Provider, B Other Clinic	Provider, Default Oregon Health and Science U
--------------------------	---

[Customize provider letter](#)

Clinical Outcomes Research Initiative

www.cori.org

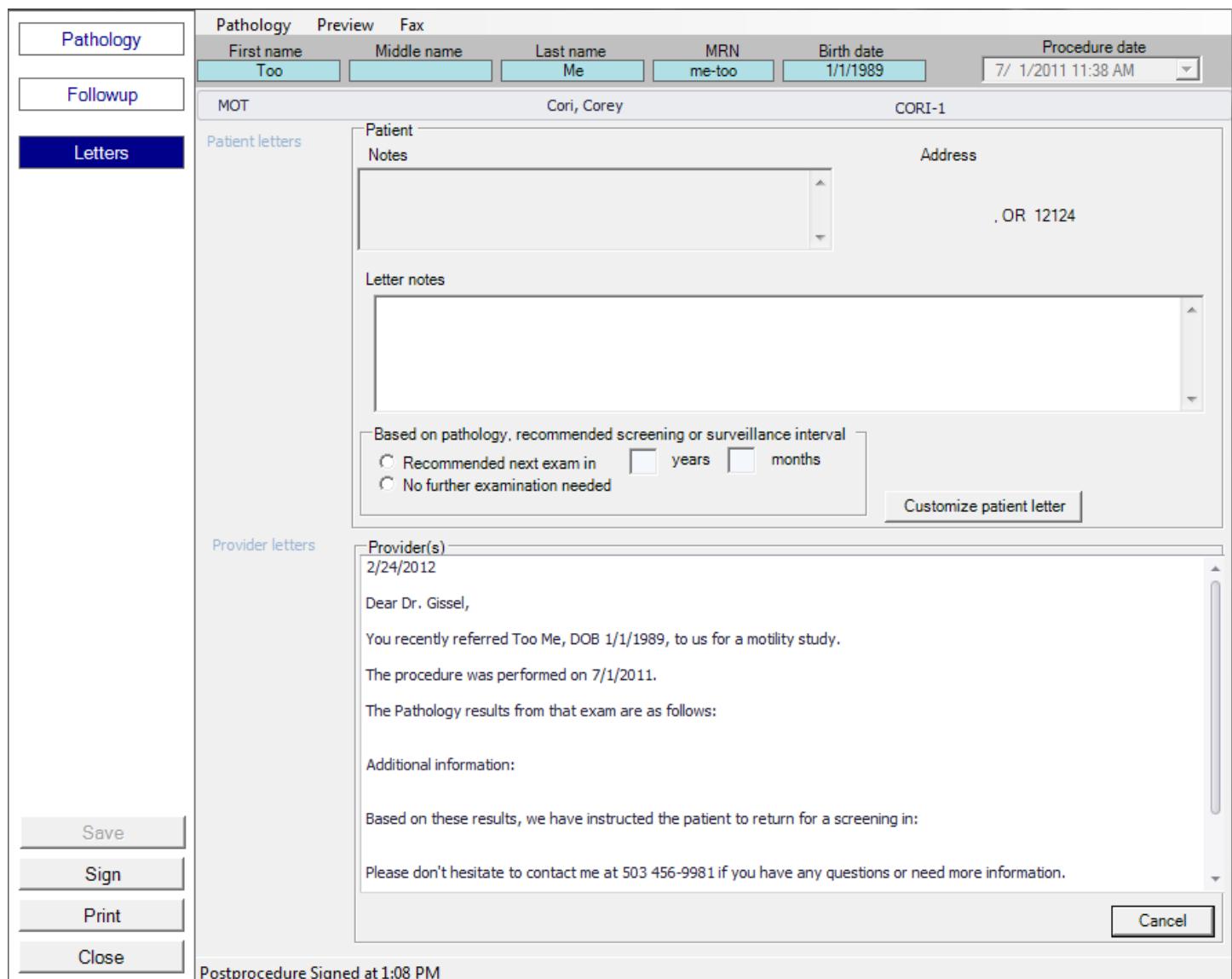
Page 89 of 100

To customize the provider letter:

1. Click on **Customize provider letter** to display the text of the letter in a panel overlaying the provider letter area.

NOTE: If CORI v4 is configured to use a different letter for copied providers, clicking on "Customize provider letter" displays the referring provider's letter in a panel with two tabs. The second tab displays the letter to the copied providers, which can be edited like the referring provider letter.

2. Make the desired changes.
3. Sign the post procedure record.



Pathology Preview Fax

First name Middle name Last name MRN Birth date Procedure date

Too Me me-too 1/1/1989 7/1/2011 11:38 AM

MOT Cori, Corey CORI-1

Patient letters

Patient Notes Address

. OR 12124

Letter notes

Based on pathology, recommended screening or surveillance interval

Recommended next exam in years months
 No further examination needed

Customize patient letter

Provider letters

2/24/2012

Dear Dr. Gissel,

You recently referred Too Me, DOB 1/1/1989, to us for a motility study.

The procedure was performed on 7/1/2011.

The Pathology results from that exam are as follows:

Additional information:

Based on these results, we have instructed the patient to return for a screening in:

Please don't hesitate to contact me at 503 456-9981 if you have any questions or need more information.

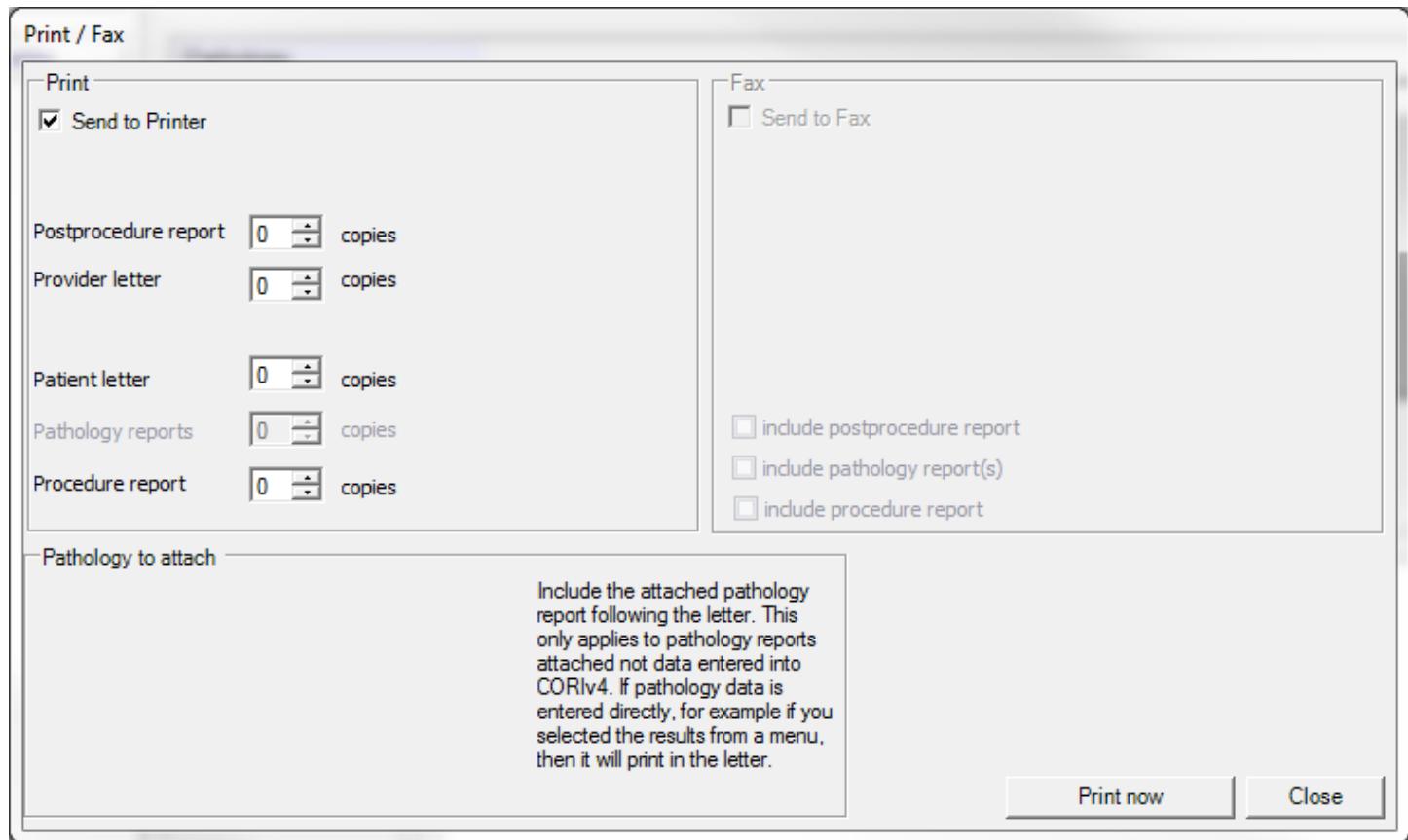
Save Sign Print Close

Postprocedure Signed at 1:08 PM

The overlay panels are removed from the display once the letter has been printed. The letter can be viewed by clicking the proper link entry in the list of printed letters at the left side of the letter area, or by clicking on the "view" link in the corresponding entry in the activity log.

Printing Postprocedure Documents

Once the postprocedure record has been signed, it can be printed and/or faxed, much like the procedure report. Clicking on “Print” displays the following dialog:



In the Print area, the number of copies to print can be set for each of the postprocedure documents. Note that when CORI v4 is configured to provide a different letter to the copied providers, the “Provider letter” field represents the number of copies of each provider letter to be printed. Thus, selecting “1” in the field causes one copy of the letter to the referring provider to be printed, as well as one copy of the letter to each of the copied providers, for each copied provider.

The “Send to Printer” checkbox is checked by default. Unchecking this prevents any documents from being printed, regardless of the settings of the “copies” fields. This can be useful if there is a need to fax documents but not print them, for example.

The Fax area allows the fax recipients of the postprocedure documents to be determined. Selecting the checkbox next to a provider’s name designates the provider to receive a fax of the appropriate provider letter. To include a copy of the postprocedure report, or one or more imported pathology reports, to the selected providers, select the appropriate checkbox. The “Send to Fax” field is unchecked by default. Checking this causes faxing to occur simultaneously with printing.

When designating pathology reports to be printed or faxed in the Print or Fax areas, the "Pathology to attach" area is used to select one or more pathology reports to be printed or faxed. Checking the box next to the date/time of a pathology report includes the report in both the print and fax jobs. Clicking on the "view" link next to an entry displays the report in a preview window.

Clicking on  causes all print and fax jobs to be sent.

Importing and Exporting in CORI v4

CORI v4 is able to import information from various sources, using various methods. Patient information (ADT), orders data, images and pathology reports can be brought into CORI v4 electronically.

Additionally, electronic image and pathology files can be retrieved directly from a computer resource (e.g. network server, external hard drive, USB flash drive, etc.).

These capabilities must be set up by CORI personnel, working with the Site Administrator and local IT personnel. This chapter discusses the import and export capabilities of CORI v4.

Patient Information

Patient demographic information (ADT) can be imported from an electronic health record system that has been configured to interface with CORI v4. To import a patient record:

1. Search for the desired patient record as described in [Searching Records in CORI v4](#).
2. The Patient Import screen appears, with search criteria from the Patient Page entered and a search already performed.

Search for patient record

Select a patient to import into Cori v4, and then click OK.

	Last name	First name	MRN	DOB
▶	TEST	BABY	7459370	3/1/2008
	TEST	ED	7459389	12/26/1956
	TEST	BETTY	7459518	5/16/1964
	TEST	DARCELLA	7459724	9/9/1999
	TEST	AD	7459858	8/7/1967
	TEST	DANYELLE	7459888	12/31/2003
	TEST	EXP48	7459986	11/10/1980
	TEST	EXP49	7459990	3/3/1988
	TEST	EXP50	7459991	10/15/1990
	TEST	EXP51	7459992	12/15/1990
	TEST	EXP52	7459993	8/8/1975
	TEST	ACC	7459994	12/12/1950
	TEST	ACC	7460003	1/1/1975
	TEST	ACC	7460004	12/12/1978
	TEST	EXP60	7460030	6/10/1988
	TEST	ACCOUNT	7460291	12/12/1958

Results 1 - 16 of 16 patients

Detailed Information for Selected Patient

Last name	TEST
First name	BABY
Mid Name	
DOB	03/01/2008
MRN	7459370
Gender	<input checked="" type="radio"/> female <input type="radio"/> male
Address 1	13111 RACIMO DRIVE
Address 2	
City	WHITTIER
State	CA
Country	
Zip	90605
Phone 1	(213)555-1212
Phone 2	(323)226-6866
Notes	

OK Cancel

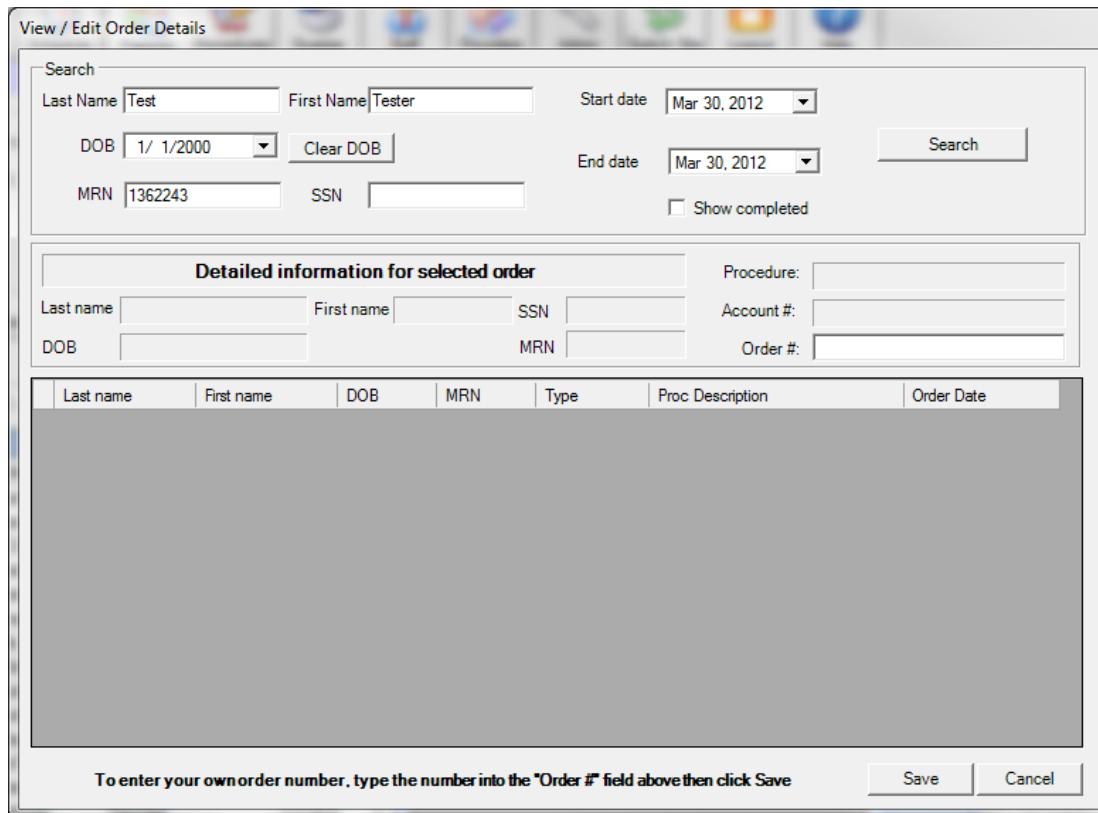
3. Click the desired row to select it for import into CORI v4. Patient information sent electronically to CORI v4 is displayed on the right.
4. Click on **OK** to return to the Patient Page, where the record now contains the imported information. Click **Cancel** to return without importing the information.
5. If the imported information included all required fields, the record will automatically be saved. Otherwise, required fields must be completed and the record saved manually.

Orders

The orders screen allows you to add Orders to any procedure created. When enabled, the Orders screen can open when a new procedure is created; there is also an option so that CORI will check for orders when the procedure is signed. There are three parts of the Orders window, a "Search By Patient" section, a search by date section, and a section for detailed information on an order.

Search By Patient: this section allows you to search by four parameters; patient name (either first or last name), Date of Birth (listed as DOB in the example below), Social Security Number (listed as SSN), and Medical Record Number (listed as MRN). Searching in any of these fields will bring up results in the main window under **"Detailed information for selected order"**.

Search by Date: Searches for Orders based on the date they were created. Selecting the menu next to "Start Date" and "End Date" display a small calendar that will allow you to select the appropriate date. Search results display under the **Detailed information for selected order**.

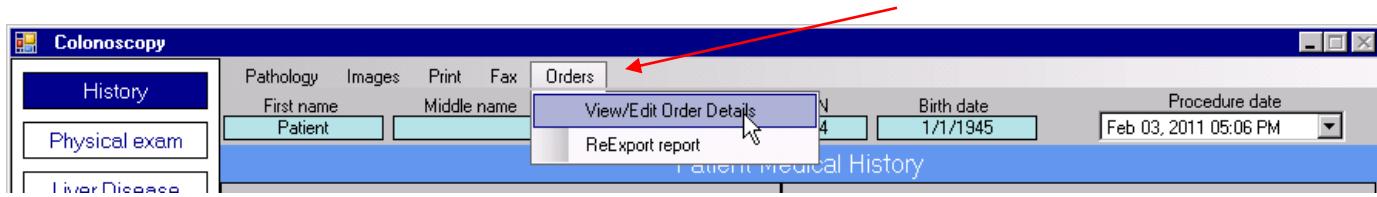


The screenshot shows the 'View / Edit Order Details' window. At the top, there is a 'Search' section with fields for Last Name (Test), First Name (Tester), Start date (Mar 30, 2012), DOB (1/1/2000), End date (Mar 30, 2012), MRN (1362243), SSN, and a 'Search' button. Below this is a section titled 'Detailed information for selected order' with fields for Last name, First name, SSN, Account #, DOB, MRN, and Order #. At the bottom, there is a table with columns: Last name, First name, DOB, MRN, Type, Proc Description, and Order Date. A note at the bottom says: 'To enter your own order number, type the number into the "Order #" field above then click Save'. At the very bottom are 'Save' and 'Cancel' buttons.

Detailed Information Section

1. The only editable field in this screen is the "Order #:" text box.
2. If the order number is missing or incorrect, change it to the correct order number.
3. Click on **Save** to save the correct order number, or on **Cancel** to discard the changes and return to the Procedure Window.
4. You can hide Completed Orders by checking the box next to "Hide Completed Orders". This makes sure you cannot accidentally use orders already attached to another report.

This screen can also be displayed by selecting "View/Edit Order Details" in the Orders menu.

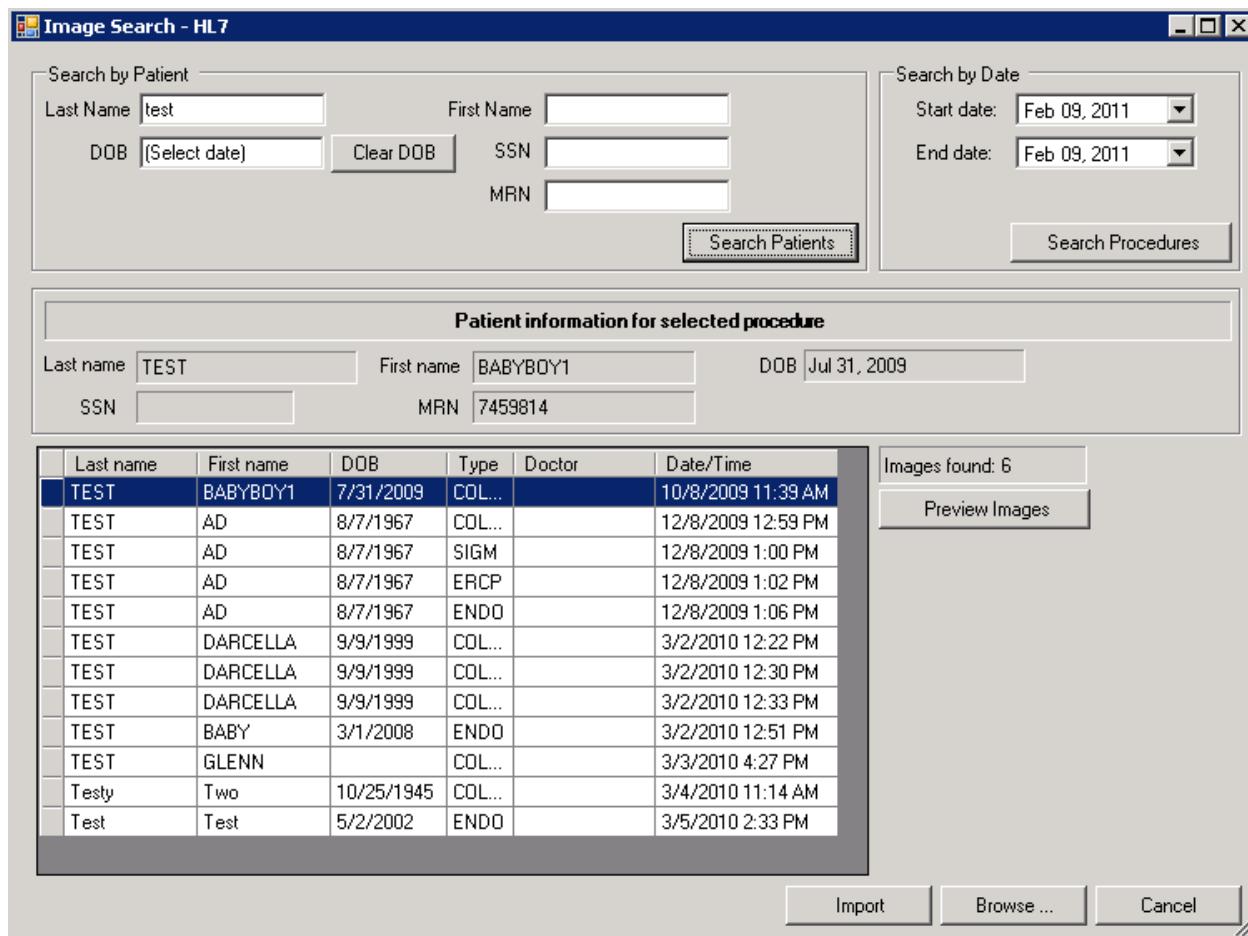


Images

Endoscopic images can be imported into CORI v4 using an electronic interface to an image management system, or by selecting files on an attached resource, such as a network drive or a USB flash drive. JPEG (.jpg, .jpeg), BMP (.bmp) and TIF (.tif, .tiff) image formats are supported.

To import images using an HL7 Interface:

1. In the Findings Section, select "Import Images" in the Images menu, or click on **Import Images**.
2. The Image Search screen appears, with search criteria from the current procedure entered and a search already performed.

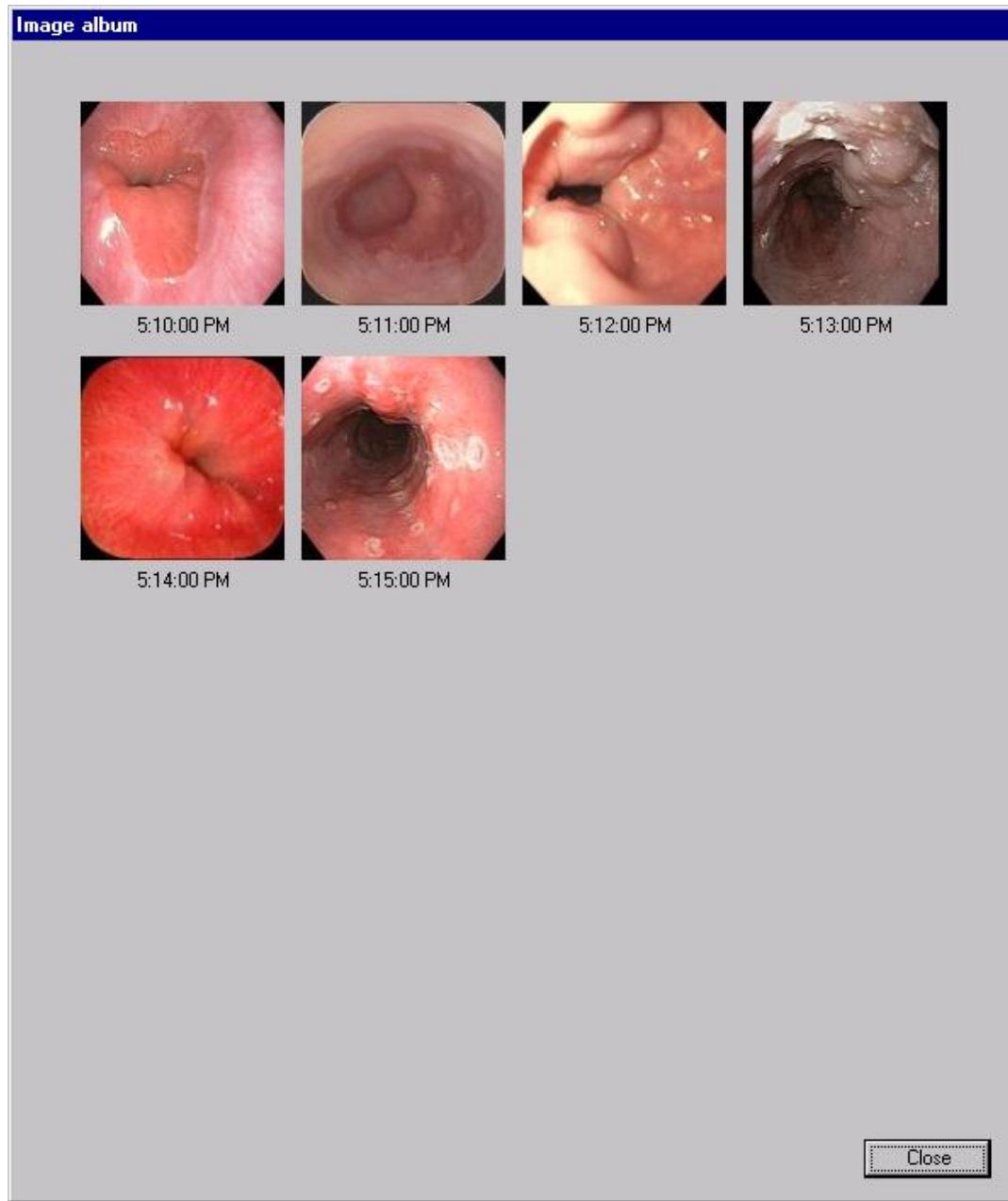


Patient information for selected procedure

Last name	First name	DOB	Type	Doctor	Date/Time
TEST	BABYBOY1	7/31/2009	COL...		10/8/2009 11:39 AM
TEST	AD	8/7/1967	COL...		12/8/2009 12:59 PM
TEST	AD	8/7/1967	SIGM		12/8/2009 1:00 PM
TEST	AD	8/7/1967	ERCP		12/8/2009 1:02 PM
TEST	AD	8/7/1967	ENDO		12/8/2009 1:06 PM
TEST	DARCELLA	9/9/1999	COL...		3/2/2010 12:22 PM
TEST	DARCELLA	9/9/1999	COL...		3/2/2010 12:30 PM
TEST	DARCELLA	9/9/1999	COL...		3/2/2010 12:33 PM
TEST	BABY	3/1/2008	ENDO		3/2/2010 12:51 PM
TEST	GLENN		COL...		3/3/2010 4:27 PM
Testy	Two	10/25/1945	COL...		3/4/2010 11:14 AM
Test	Test	5/2/2002	ENDO		3/5/2010 2:33 PM

NOTE: If there are no search results, or too many results, change search criteria and search again, or search by date range.

3. Search results are displayed below the patient information area.
4. Select a patient row to display a count of the images available for this patient on the right.
5. Click on **Preview Images** to view the images available for import.



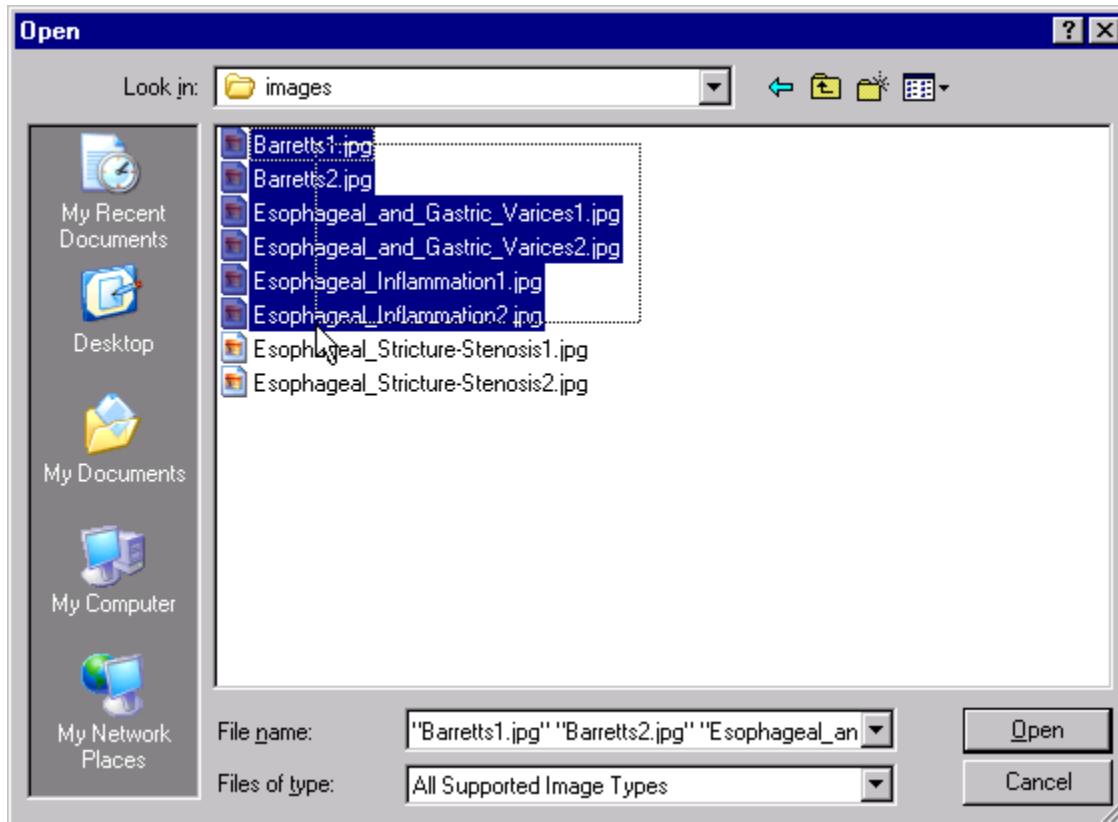
6. Click on **Close** to return to the Image Search screen.
7. Click on **Import** to import the images into the procedure record.

For an image to be displayed on the procedure report, it must be associated with a finding. See [Adding Images to Findings](#) for information on associating images with findings.

To import images using a File Open dialog:

1. Select Import Images from the Images menu, or click on **Import Images** in the Findings Section to display the Open dialog.

NOTE: If CORI v4 is configured to interface with an electronic imaging system, the Image Search screen will open (see [Importing Images Using an HL7 Interface](#)). Click **Browse ...** at the bottom of the screen to display the Open dialog.



2. Navigate to the location of the image file and select it. If multiple images are desired, drag across the filenames to select them, or hold down CTRL and select individual files.
3. Click on **Open** to import the pictures into the procedure, or on **Cancel** to return to the Findings Detail screen without selecting any images.

For an image to be displayed on the procedure report, it must be associated with a finding. See [Adding Images to Findings](#) for information on associating images with findings.

Pathology

Pathology results can be imported into CORI v4 using an interface to an electronic pathology management system.

Exporting Information from CORI v4

CORI v4 has the ability to export signed procedure reports to an electronic health record system, such as an EMR. This export can be in the form of a text file, or as a PDF with all diagrams and images embedded within it. This type of export is usually by an HL7 interface.

When configured, an HL7-based export automatically occurs each time the procedure report is electronically signed. Note that a fellow signing the report performs the export, and the report will be exported again when the attending signs.

In addition, procedure report text can be copied to the Windows clipboard for pasting into other applications. To do this, select "Copy report text to clipboard" from the Print menu in the Procedure Window.

Contact Information

If you have any questions regarding CORI v4's Queries, please contact us at cori@ohsu.edu or call the CORI support line at 1-888-786-2674.